

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

114.3 CMR 39.00: REHABILITATION CENTER SERVICES, AUDIOLOGICAL SERVICES,  
RESTORATIVE SERVICES

Section

- 39.01: General Provisions
- 39.02: General Definitions
- 39.03: General Rate Provisions
- 39.04: Allowable Fees
- 30.05: Filing and Reporting Requirements
- 39.06: Severability

39.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 39.00 governs the rates of payment to be used by all governmental units for rehabilitation center services, audiological services and restorative services provided to publicly-aided individuals by eligible providers. Rates for services rendered to individuals covered by M.G.L. c. 152 (Workers Compensation) are set forth at 114.3 CMR 40.06(12). 114.3 CMR 39.00 shall be effective on June 1, 2011.

(2) Coverage. Except as provided otherwise, 114.3 CMR 39.00 and the rates of payment contained in 114.3 CMR 39.00 shall apply to services rendered to eligible providers of rehabilitation center services, audiological services, and restorative services to publicly-aided individuals. The rates of payment specified in 114.3 CMR 39.00 are full compensation for professional services rendered, as well as for any administrative or supervisory duties.

(3) Exceptions. Rates of payment contained in 114.3 CMR 39.00 do not apply to indirect services, such as case conferences or in-service education programs provided by eligible providers in long-term care facilities.

(4) Coding Updates and Corrections. The Division may publish procedure code updates and corrections in the form of an Administrative Bulletin. The publication of such updates and corrections will list:

- (a) codes for which the code numbers only changed, with the corresponding cross-reference;
- (b) codes for which the code remains the same but the description has changed;
- (c) deleted codes for which there is no cross-reference; and
- (d) for entirely new codes which require new pricing, the Division will list these codes and apply individual consideration in reimbursing for these new codes until appropriate rates can be developed.

(5) Administrative Bulletins. The Division may issue administrative bulletins to clarify its policy on and understanding of substantive provisions of 114.3 CMR 39.00.

(6) Disclaimer of Authorization of Services. 114.3 CMR 39.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 114.3 CMR 39.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services extended to publicly-aided clients.

(7) Authority. 114.3 CMR 39.00 is adopted pursuant to M.G.L. c. 118G.

39.02: General Definitions

Meaning of Terms. In addition to the general definitions contained in 114.3 CMR 2.00, terms used in 114.3 CMR 39.00 shall have the meaning set forth in 114.3 CMR 39.02.

Assessment for a Hearing Aid. A procedure which includes:

- (a) Assessment of a patient's performance by appropriate tests with hearing aid devices;
- (b) A recheck of the patient and hearing aid after the prescribed aid has been fitted and used for a trial period; and
- (c) Counseling related to the patient's adjustment to the use of the hearing aid.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.02: continued

Audiological and Hearing Services. Testing related to the determination of hearing loss, evaluation of hearing aids, the prescription of hearing aid devices, and aural rehabilitation which includes lip-reading and auditory training.

Aural Rehabilitation. Therapy provided by a qualified audiologist either in a group or individually.

- (a) Lip-reading: Training of the visual modality to improve the understanding of the speech or language of other speakers.
- (b) Auditory Training: Training of the auditory modality to improve the understanding of the speech or language of other speakers.

Complete Audiological Evaluation. A routine audiological evaluation plus site of Lesion Testing (Impedance Testing and/or Recruitment Testing) as needed or recommended by a physician.

Comprehensive Restorative and Rehabilitation Center Evaluation. An all-inclusive, in-depth assessment of recipient's medical condition and level of functioning and limitations, to determine the need for treatment and, if necessary, to develop a plan of treatment. The comprehensive evaluation includes a written report.

Division. The Division of Health Care Finance and Policy, established under M.G.L. c. 118G.

Electroacoustic Evaluation for a Hearing Aid, Binaural. A complete audiological evaluation with a check of the patient's personal hearing aid (includes hearing aid evaluation and electroacoustical analysis of the aid).

Eligible Provider of Audiological and Hearing Services. A provider acting within the scope of the provider's license, in accordance with all applicable state and federal laws, who meets such conditions of participation by a governmental unit purchasing audiological services or by purchasers under M.G.L. c. 152; and

- (a) an audiologist who is currently licensed by the Massachusetts Board of Speech-language Pathology and Audiology; or
- (b) any speech and hearing center (proprietorship, partnership or corporation) which is not part of a hospital and provides authorized speech, hearing or language services rendered by a qualified audiologist or speech pathologist and does not bill separately from such facility for professional services; or
- (c) an audiology assistant who is currently licensed by the Massachusetts Board of Registration in Speech-language Pathology and Audiology; or
- (d) a hearing instrument specialist who is currently licensed by the Massachusetts Board of Registration of Hearing Instrument Specialists.

Eligible Provider of Rehabilitation Center Services. Freestanding centers providing rehabilitation services which are licensed by the Massachusetts Department of Public Health, and which meet such conditions of participation as may be required by a governmental unit purchasing rehabilitation services, or by a purchaser under M.G.L. c. 152.

Eligible Provider of Restorative Services. A provider who meets such conditions of participation by a governmental unit purchasing restorative services or by purchasers under M.G.L. c. 152; and

- (a) a physical therapist who is currently licensed by the Massachusetts Board of Registration in Allied Health Professions; or
- (b) a physical therapy assistant who is currently licensed by the Massachusetts Board of Registration in Allied Health Professions; or
- (c) an occupational therapist who is currently licensed by the Massachusetts Board of Registration in Allied Health Professions and certified by the National Board of Certification in Occupational Therapy; or
- (d) an occupational therapy assistant who is licensed by the Massachusetts Board of Registration in Allied Health Professions; or
- (e) a speech therapist who is currently licensed by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology and certified by the American Speech, Language and Hearing Association; or
- (f) any speech and hearing center (proprietorship, partnership or corporation) which provides authorized speech or language services rendered by a qualified speech pathologist who does not bill separately from such facility for professional services rendered.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.02: continued

Governmental Unit. The Commonwealth of Massachusetts, or any of its departments, agencies, boards, commissions or political subdivisions.

Group Session. Therapeutic services directed toward more than one patient in a single visit, utilizing group participation as a treatment technique.

HCPCS. The Healthcare Common Procedure Coding System.

Hearing Aid Check. A check of the functioning of the patient's monaural or binaural hearing aid

Individual Consideration (I.C.). Services for which there is no specified rate and for which the purchasing agency determines the appropriate payment amount. The purchasing agency determines the appropriate payment based on the provider's report of services provided, and documentation as requested by the purchasing agency. The report shall include a pertinent history and diagnosis, a description of the service rendered and the length of time spent with the patient. In making the determination of the appropriate payment amount, the purchasing agency shall use the following criteria:

- (a) policies, procedures and practices of other third party purchasers of care, both governmental and private;
- (b) the severity and complexity of the patient's disorder or disability;
- (c) prevailing provider ethics and accepted practice;
- (d) time, degree of skill, and cost including equipment cost required to perform the procedure(s).

Medical Evaluation. While this phrase appears as part of HCPCS nomenclature, it should not be literally interpreted; evaluations may be performed by the appropriate staff as determined by the eligible provider.

---

Non-organic Test Battery. Tests done to determine functional hearing loss.

Office Visit. Patient treatments rendered in a speech and hearing center, a licensed clinic or center, or in a practitioner's office (whether an individual practice, a group practice or an association of practitioners). If a practitioner has an office in his or her home that is used for patient treatment then services rendered there would be billed as office visits.

Out-of-office Visit. Patient treatments rendered in a nursing home, school, a patient's home or in any other setting where the practitioner travels from his or her usual place of business to render patient treatment.

Physician's Comprehensive Rehabilitation Evaluation. A cardiopulmonary, neuromuscular, orthopedic and functional assessment performed at a rehabilitation center by a physician.

Publicly Aided Individual. A person who receives health care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

Rehabilitation. The process of providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of the physically disabled individual, in a program designed to achieve objectives of improved health and welfare with realization of his or her maximum physical, social, psychological and vocational potential.

Restorative Services. Services provided by a physical therapist, an occupational therapist or a speech pathologist at the referral of a physician for the purpose of maximum reduction of physical and speech disability and restoration of the patient to a maximum functional level.

Routine Audiological Evaluation. A procedure which includes:

- (a) Pure tone audiogram, by air and bone conduction testing.
- (b) Speech reception and discrimination testing.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

39.02: continued

Speech/Language Pathology Services. The evaluation and treatment of communicative disorders with regard to the functions of articulation (including aphasia and dysarthria), language, voice and fluency.

39.03: General Rate Provisions

(1) Rate Determination. Rates of payment for authorized services to which 114.3 CMR 39.00 applies shall be the lower of:

- (a) the eligible provider's usual fee to patients other than publicly-aided; or
- (b) the schedule of allowable fees set forth in 114.3 CMR 39.04.

(2) Out-of-office Rates. With the exception of services provided by rehabilitation centers and speech and hearing centers, the fee for any service provided out of the office will be 115% of the respective in-office fee.

(3) Multiple Procedures in Physical Therapy. The performance of more than one type of physical therapy treatment in a single visit. Under such circumstances, the provider shall receive 100% of the applicable fee for each procedure, with a maximum of four procedures (or a total of one hour) allowed in a given visit.

(4) Special Contracts. In certain circumstances, purchasing agencies may pay for services on an hourly basis, rather than a per visit basis as required by 114.3 CMR 39.00, as described in 114.3 CMR 39.00. A special contract would be appropriate where a large number of patients are treated by an individual practitioner on a regular basis for a particular purchaser at one site and/or where the treatment times described in the procedure codes in 114.3 CMR 39.00 do not define the treatment times authorized by the purchaser.

(5) Two Providers of Audiological Services. Under certain circumstances, in accordance with purchasing agency's specifications, it may be appropriate for two providers of audiological services to work together to perform hearing evaluations. In such situations, each provider uses the TG modifier for complex/high tech level care, along with the applicable service code. The fee for each audiologist will be 86% of the listed fee for that service.

39.04: Allowable Fees

(1) Fee Schedule.

Service Code	Allowable Fee	Service Description
<i>Special Otorhinolaryngologic Services</i>		
92506	\$52.16	Evaluation of speech, language, voice, communication, and/or auditory processing (per hour, maximum of three hours)
92506 HA	\$52.16	Evaluation of speech, language, voice, communication, auditory processing, child/adolescent program (for patients aged 21 or younger) (per hour, with maximum of four hours)
92506 TF	\$52.16	Evaluation of speech, language, voice, communication, auditory processing, rehabilitation status; intermediate level of care; (use for developmentally disabled adults aged 22 or older, per hour, maximum of three hours)
92507	\$59.62	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual (maximum one unit per visit)
92508	\$25.53	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals (maximum one unit per visit)
92526	\$22.79	Treatment of swallowing dysfunction and/or oral function for feeding; (maximum one unit per visit)
<i>Vestibular Function Tests, With Recording, and Medical Diagnostic Evaluation</i>		
92541	\$45.80	Spontaneous nystagmus test, including gaze and fixation

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

Service Code	Allowable Fee	Service Description
		nystagmus, with recording
92542	\$47.26	Positional nystagmus test, minimum of four positions, with recording
92543	\$35.10	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	\$37.89	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
92545	\$34.48	Oscillating tracking test, with recording
92546	\$71.48	Sinusoidal vertical axis rotational testing
92547	\$21.51	Use of vertical electrodes (List separately in addition to code for primary procedure)
<i>Audiologic Function Tests With Medical Diagnostic Evaluation</i>		
92551	\$8.33	Screening test, pure tone, air only
92552	\$16.12	Pure tone audiometry (threshold); air only
92553	\$23.04	Pure tone audiometry (threshold); air and bone
92555	\$13.20	Speech audiometry; threshold
92556	\$19.47	Speech audiometry; threshold; with speech recognition
92557	\$43.43	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92562	\$16.44	Loudness balance test, alternate binaural or monaural
92563	\$14.17	Tone decay test
92564	\$16.01	Short increment sensitivity index (SISI)
92565	\$12.55	Stenger test, pure tone
92567	\$17.85	Tympanometry (impedance testing)
92568	\$12.51	Acoustic reflex decay testing
92569	\$13.22	Acoustic decay testing
92572	\$ 7.36	Staggered spondaic word test
92576	\$16.33	Synthetic sentence identification test
92577	\$20.98	Stenger test, speech
92579	\$25.96	Visual reinforcement audiometry (VRA)
92582	\$27.91	Conditioning play audiometry
92583	\$28.99	Select picture audiometry
92584	\$73.99	Electrocochleography
92585	\$82.80	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	\$59.49	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	\$49.64	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	\$69.47	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and distortion product otoacoustic emissions at multiple levels and frequencies)
92590	\$21.26	Hearing aid examination and selection, monaural
92591	\$31.53	Hearing aid examination and selection; binaural
92592	\$13.33	Hearing aid check, monaural
92593	\$26.65	Hearing aid check, binaural
92594	\$36.53	Electroacoustic evaluation for hearing aid, monaural
92595	\$73.09	Electroacoustic evaluation for hearing aid, binaural.
92596	\$23.36	Ear protector attenuation measurements

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

Service Code	Allowable Fee	Service Description
<i>Evaluative and Therapeutic Services</i>		
92601	\$126.14	Diagnostic analysis of cochlear implant, patient younger than seven years of age; with programming
92602	\$86.54	Diagnostic analysis of cochlear implant, patient younger than seven years of age; subsequent reprogramming (do not report 92602 in addition to 92601)
92603	\$79.40	Diagnostic analysis of cochlear implant, age seven years or older; with programming
92604	\$51.49	Diagnostic analysis of cochlear implant, age seven years or older; subsequent reprogramming (do not report 92604 in addition to 92603)
92605	\$52.16	Evaluation for prescription of non-speech-generating augmentative and alternative communication device
92606	\$13.04	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	\$52.16	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	\$26.08	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
92609	\$13.04	Therapeutic services for the use of speech-generating device, including programming and modification
92610	\$52.16	Evaluation of oral and pharyngeal swallowing function (per hour, maximum of one hour)
92620	\$52.16	Evaluation of central auditory function, with report; initial 60 minutes
92621	\$13.04	Evaluation of central auditory function, with report; each additional 15 minutes (up to the maximum of eight units billed)
92626	\$52.16	Evaluation of auditory rehabilitation status; first hour
92627	\$13.04	Evaluation of auditory rehabilitation status; each additional 15 minutes (list separately in addition to code for primary procedure)
92630	\$13.04	Auditory rehabilitation; prelingual hearing loss
92633	\$13.04	Auditory rehabilitation; postlingual hearing loss
<i>Other Procedures</i>		
92700	I.C.	Unlisted otorhinolaryngologic service or procedure
<i>Physical Medicine and Rehabilitation</i>		
97001	\$52.16	Physical therapy evaluation (per hour, maximum of two hours)
97001 HA	\$52.16	Physical therapy evaluation; child/adolescent program (for patients age 21 or under, per hour with a maximum of three hours)
97001 TF	\$52.16	Physical therapy evaluation; intermediate level of care (for developmentally disabled adults aged 22 or older, per hour with a maximum of three hours)
97002	\$52.16	Physical therapy re-evaluation (per hour)
97003	\$52.16	Occupational therapy evaluation (per hour, maximum of two hours)
97003 HA	\$52.16	Occupational therapy evaluation; child/adolescent program (for patients aged 21 or under per hour with maximum of three hours)
97003 TF	\$52.16	Occupational therapy evaluation; intermediate level of care; (for developmentally disabled adults aged 22 or older, per hour with maximum of three hours)
97004	\$52.16	Occupational therapy re-evaluation (per hour)

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

Service Code	Allowable Fee	Service Description
<i>Modalities—Supervised</i>		
97010	\$3.79	Application of a modality to one or more areas; hot or cold packs
97012	\$11.22	Traction, mechanical
97014	\$11.27	Electrical stimulation (unattended)
97016	\$11.59	Vasopneumatic devices
97018	\$5.74	Paraffin bath
97022	\$4.12	Whirlpool
97024	\$3.79	Diathermy (e.g., microwave)
97026	\$4.66	Infrared
97028	\$3.79	Ultraviolet
<i>Modalities--Constant Attendance</i>		
97032	\$13.04	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	\$13.04	Iontophoresis, each 15 minutes
97034	\$13.04	Contrast baths, each 15 minutes
97035	\$13.04	Ultrasound, each 15 minutes
97036	\$13.04	Hubbard tank, each 15 minutes
97039	\$13.04	Unlisted modality (specify type and time if constant attendance)
<i>Therapeutic Procedures</i>		
97110	\$13.04	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	\$13.04	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities (each 15 minutes)
97113	\$13.04	Aquatic therapy with therapeutic exercises (each 15 minutes)
97116	\$13.04	Gait training (includes stair climbing) (each 15 minutes)
97124	\$13.04	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (each 15 minutes)
97139	\$13.04	Unlisted therapeutic procedure (specify) (each 15 minutes)
97140	\$13.04	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	\$20.70	Therapeutic procedure(s), group (two or more individuals) (services delivered under an outpatient plan of care) (maximum one unit per visit)
97530	\$13.04	Therapeutic Activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	\$13.04	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	\$13.04	Sensory integrative techniques to enhance memory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	\$13.04	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97537	\$13.04	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97542	\$13.04	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	\$104.32	Work hardening/conditioning; initial two hours

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

Service Code	Allowable Fee	Service Description
97546	\$52.16	Each additional hour (list separately in addition to code for primary procedure) (use in conjunction with 97545)
<i>Active Wound Care Management</i>		
97597	\$41.82	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	\$52.34	Total wound(s) surface area greater than 20 square centimeters
97602	I.C.	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	\$27.05	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	\$28.95	Total wound(s) surface area greater than 50 square centimeters
<i>Tests and Measurements</i>		
97750	\$13.04	Physical performance test or measurement (e.g. musculoskeletal, functional capacity), with written report, each 15 minutes
97755	\$13.04	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
<i>Orthotic Management and Prosthetic Management</i>		
97760	\$13.04	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremities, lower extremities and/or trunk, each 15 minutes
97761	\$13.04	Prosthetic training, upper and/or lower extremities, each 15 minutes
97762	\$13.04	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
<i>Other Procedures</i>		
97799	\$13.04	Unlisted physical medicine/rehabilitation service or procedure services delivered under an outpatient therapy plan of care (each 15 minutes, maximum six units per visit)
<i>Evaluation and Management--Office or Other Outpatient Services</i>		
99203	\$75.00	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity
99205	\$142.46	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components (written report required): - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity
99212	\$30.39	Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: - a problem focused history - a problem focused examination; and - straightforward medical decision making
99214	\$73.71	Office or other outpatient visit for the evaluation and management

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.04: continued

Service Code	Allowable Fee	Service Description
		of an established patient which requires at least two of these three key components (written report required): - a detailed history; - a detailed examination; and - medical decision making of moderate complexity
99215	\$99.52	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components (written report required): - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity
<i>Miscellaneous</i>		
L7510 MS	I.C.	Repair of prosthetic device, repair or replace minor parts, six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty (for use only for the purchase of a cochlear implant service contract in accordance with 130 CMR 426.416(J))
V5008	\$27.05	Hearing screening (non-organic test battery)
V5010	\$54.86	Assessment for hearing aid (initial visit)
V5011	I.C.	Fitting/orientation/checking of hearing aid

(2) Hourly Rates for I.C. Designated Services, Special Contracts, and Non-listed Procedures. As a guideline, rates for restorative, audiological and rehabilitation center services for aquatic therapy, nautilus training, work evaluations/job site analysis, work hardening programs and other unlisted services shall be determined by applying the appropriate portion of the hourly rate specified in 114.3 CMR 39.04(2): *Hourly Rates for Innovative Purchasing Contracts, Individual Consideration and Non-listed Procedures.* Diagnostic procedures that require specialized machinery, such as muscle testing during isometric and isokinetic exercises (e.g., use of cybex machine) should be reimbursed with consideration for additional equipment costs and technical assistance, in addition to the prorated hourly fee for therapists' services and routine overhead expenses.

Rehabilitation Center Physical Therapist	\$52.16/hr.
Rehabilitation Center Occupational Therapist	\$52.16/hr.
Rehabilitation Center Speech Therapist	\$52.16/hr.
Audiologist Services	\$52.16/hr.
Restorative Physical Therapy office visit	\$52.16/hr.
Restorative Occupational Therapy office visit	\$52.16/hr.
Restorative Speech Therapy office visit	\$52.16/hr.
Restorative Physical Therapy out-of-office visit	\$60.00/hr.
Restorative Occupational Therapy out-of-office visit	\$60.00/hr.
Restorative Speech Therapy out-of-office visit	\$60.00/hr.

39.05: Filing and Reporting Requirements

(1) Upon the request of the Division, Eligible Providers must submit cost information or other data by the deadline specified by the Division.

(2) Extension of Filing Date. The Division may grant an extension of time for the submission of cost or other data upon the written request from the provider demonstrating that good cause exists for such an extension.

114.3 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY  
AMBULATORY CARE

39.05: continued

(3) Penalties. The Division may reduce the payment rates by 15% for any Provider that fails to submit required information, subject to the approval of the purchasing governmental unit. The Division will notify the Provider in advance of its intention to impose a rate reduction. The rate reduction will remain in effect until the required information is submitted to the Division.

39.06: Severability

The provisions of 114.3 CMR 39.00 are severable, and if any provision of 114.3 CMR 39.00 or application of such provision to any provider covered under 114.3 CMR 39.00 or any circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.3 CMR 39.00 or application of such provisions to providers covered under 114.3 CMR 39.00 or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 39.00: M.G.L. c. 118G.