Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter CHC-102
January 2015

TO: Community Health Centers Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Community Health Center Manual* (Gender Dysphoria, Sterilization, Hysterectomy, and Laboratory Services Policy)

This letter transmits revisions to the Community Health Center (CHC) regulations as they pertain to treatment for gender dysphoria, sterilization services, hysterectomy services, and laboratory services. This letter also transmits related updates to Subchapter 6 of the *Community Health Center Manual*.

Gender Dysphoria Policy

MassHealth has amended its regulations to allow coverage of the treatment of gender dysphoria, including gender reassignment surgeries and hormone therapies.

Gender reassignment surgeries and certain hormone therapies require prior authorization. Providers should review the Guidelines for Medical Necessity Determination for Gender Reassignment Surgery, available at www.mass.gov/masshealth/guidelines, and the MassHealth Drug List, available at https://masshealthdruglist.ehs.state.ma.us/MHDL, for more information on prior authorization requirements.

Sterilization Provisions

MassHealth has clarified in its CHC regulations that a provider does not need to submit a copy of the MassHealth Consent for Sterilization Form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the updated regulations provide that the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim:

(A) the medical procedure, treatment, or operation was unilateral and did not result in sterilization;

(B) the medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes;

(C) the medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(D) the medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. The physician must also include the nature and date of the life-threatening emergency.

In addition, under the circumstances referenced in (A) and (C), above, the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

These changes continue to conform to federal standards. MassHealth has also conformed relevant sterilization provisions in the CHC regulations to the other MassHealth provider regulations for consistency purposes and has updated certain terminology. Please see 130 CMR 405.428 through 405.430, and relevant definitions, for more information and the applicable sterilization provisions.

Hysterectomy Provisions

The CHC regulations have also been updated to include rules concerning hysterectomy services, which mirror existing language in the MassHealth physician regulations and do not represent new policy. See 130 CMR 405.424.

Related Updates to Subchapter 6 of the Community Health Center Manual

Revisions to Subchapter 6 of the *Community Health Center Manual* have also been made, as necessary, related to the CHC regulatory changes concerning gender dysphoria and sterilization services referenced above.

The gender dysphoria-related updates to Subchapter 6 include revisions to the relevant service codes in Section 606, "Payable Surgery Codes". Service codes for which prior authorization is required for gender dysphoria-related services are identified by "PA for Gender Dysphoria-Related Services Only".

The sterilization-related updates to Subchapter 6 include revisions to the relevant legend entries in Section 601, "Introduction and Explanation of Abbreviations." Service codes that always require the Consent for Sterilization form will continue to be identified by CS-18 or CS-21. Service codes for which the Consent for Sterilization form must be submitted, unless the signed attachment referenced above in the "Sterilization Provisions" section is submitted with the claim, will be identified by CS-18* or CS-21*. Updates were also made as necessary to relevant service codes in Section 606 to reflect the updated legend.

Laboratory Provisions

Finally, the laboratory provisions in the CHC regulations were updated for consistency purposes to more closely align to corresponding provisions in the MassHealth *Independent Clinical Laboratory Manual* at 130 CMR 401.000.

Effective Date

These regulatory and Subchapter 6 amendments are effective for dates of service on or after January 2, 2015.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Community Health Center Manual

Pages iv, 4-1 through 4-4, 4-11 through 4-24, and 6-1 through 6-20

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Community Health Center Manual

Pages iv, and 4-13 through 4-16 — transmitted by Transmittal Letter CHC-65

Pages 4-1, 4-2, 4-11, and 4-12 — transmitted by Transmittal Letter CHC-99

Pages 4-3 and 4-4 — transmitted by Transmittal Letter CHC-72

Pages 4-17 through 4-22 — transmitted by Transmittal Letter CHC-57

Pages 4-23 and 4-24 — transmitted by Transmittal Letter CHC-73

Pages 6-1 through 6-18 — transmitted by Transmittal Letter CHC-101

4. Program Regulations

4. Program Regulations (cont.)

6. Service Codes and Descriptions

405.401: Introduction

All community health centers (CHCs) participating in MassHealth must comply with the regulations governing MassHealth, including but not limited to 130 CMR 405.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

405.402: Definitions

The following terms used in 130 CMR 405.000 have the meanings given in 130 CMR 405.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 405.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 405.000 and in 130 CMR 450.000: *Administrative and Billing Regulations.*

340B Covered Entities — facilities and programs eligible to purchase discounted drugs through a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

340B Drug-Pricing Program — a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients.

Acupuncture — the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Family Practitioner — a licensed physician who is board-eligible or board-certified in family practice. A family practitioner provides continuous, accessible medical care with emphasis on the family unit that combines appreciation of both the biomedical and psychosocial dimensions of illness. The family practitioner assumes responsibility for and provides most of the member's health care, and coordinates the member's total health needs.

Freestanding Clinic — any institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s. 51 that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. Such institutions include CHCs and mental health centers.

Group Clinic Visit — a session conducted by a physician, physician assistant, nurse practitioner, or registered nurse to introduce preventive medicine approaches to personal health and safety and to present self-help and personal management information concerning family medicine, adult medicine, sex education, and chronic illness. Tobacco cessation group clinic visits may be provided by MassHealth-qualified tobacco cessation counseling providers as defined in 130 CMR 405.472.

Health Practitioner — an individual who can diagnose and treat medical problems whether by authority of his or her own license or by the delegated authority of a licensed medical professional.

HIV Pre-Test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, nurse practitioner, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling before HIV testing. Providers will offer information on risk factors and implications of both positive and negative test results, in accordance with established protocols of the Massachusetts Department of Public Health.

HIV Post-Test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, nurse practitioner, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling after HIV testing. Such counseling will include information about the implications of positive and negative test results, risk-reduction techniques, partner notification, and referral to medical and support services, in accordance with established protocols of the Massachusetts Department of Public Health.

Home Visit — a face-to-face meeting between a member and a physician, physician assistant, nurse practitioner, or registered nurse in the member's residence for examination, diagnosis, or treatment.

Hospital Visit — a face-to-face meeting between a member and a physician, physician assistant, nurse practitioner, or registered nurse when the member has been admitted to a hospital by a physician on the CHC's staff.

Individual Medical Visit — a face-to-face meeting at the CHC between a member and a physician, physician assistant, nurse practitioner, or registered nurse for medical examination, diagnosis, or treatment.

Individual Mental Health Visit — a face-to-face meeting at the CHC between a member and a psychiatrist for mental health examination and diagnosis.

Institutionalized Individual — for purposes of 130 CMR 405.428 through 405.430, an individual who is

(1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the care and treatment of mental illness; or

(2) confined, under a voluntary commitment, in a psychiatric hospital or other facility for the care and treatment of mental illness.

Mentally Incompetent Individual — for purposes of 130 CMR 405.428 through 405.430, an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Nursing Facility Visit — a visit by a physician, physician assistant, nurse practitioner, or registered nurse to a member who has been admitted to a nursing facility, extended care facility, or convalescent or rest home.

Primary or Elective Care — medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention, and referral when necessary. This care does not require the specialized resources of a hospital emergency department.

Sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Urgent Care – medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care does not include elective or primary care.

405.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers CHC services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

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

405.404: Provider Eligibility

Payment for the services described in 130 CMR 405.000 will be made only to providers of CHC services who are participating in MassHealth on the date of service.

(A) In State. To participate in MassHealth, a CHC located in Massachusetts must meet the qualifications for certification or provisional certification in 130 CMR 405.405.

(B) Out of State. To participate in MassHealth, an out-of-state CHC must obtain a MassHealth provider number and meet the following criteria:

(1) if the center is required by its own state's law to be licensed, the center must be licensed by the appropriate state agency under whose jurisdiction it operates;

(2) the center must participate in its state's Medicaid program (or the equivalent); and

(3) the center must have a rate of payment established by the appropriate rate setting regulatory body of its state.

405.405: Certification

(A) Application. An application for certification as a CHC must be made on the form provided by the MassHealth agency and must be submitted to the MassHealth agency's program specialist for CHCs. Upon receipt of the completed application, the program specialist or his or her designee may arrange for a site visit with the applicant to determine compliance with 130 CMR 405.406 through 405.416 inclusive, and if the applicant offers one or more of the services described in 130 CMR 405.431 through 405.471, compliance with the applicable portions of those sections. Based on the information revealed by the application and the site visit, the MassHealth agency will determine whether the applicant is certifiable, provisionally certifiable, or not certifiable. The program specialist will promptly notify the applicant of the determination in writing. If the applicant is not certifiable, the notice will contain a statement of the reasons for that determination.

(B) Certification. A determination of certifiability indicates that the applicant has been found by the MassHealth agency to be in compliance with 130 CMR 405.406 through 405.416 inclusive and, to the extent applicable, with 130 CMR 405.431 through 405.471. Upon such determination of certifiability, the CHC may enter into a provider contract with the MassHealth agency in accordance with MassHealth regulations in 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Provisional Certification. Provisional certification means that the MassHealth agency has determined the applicant to be in compliance with the sections referred to in 130 CMR 405.405(B) above except for one or more of the following: 130 CMR 405.408(F) (Nutrition Services), 130 CMR 405.408(C) (Obstetrics/Gynecology), 130 CMR 405.414 (Translation Services), or 130 CMR 405.415 (Emergency Backup Services). If an applicant has been provisionally certified, the letter of notification will specify the certification requirements with which the applicant has failed to comply and the schedule for achieving compliance. When requirements for full certification have been met, the MassHealth agency will certify the CHC. Upon notice of provisional certification, the CHC may enter into a provider contract with the MassHealth agency in accordance with MassHealth regulations in 130 CMR 450.000: *Administrative and Billing Regulations*, on the condition that such provider contract, by its own terms, will expire upon the date fixed in the letter of notification for full compliance.

(D) Review of Certification.

(1) The MassHealth agency's program specialist for CHCs has the right to review a certified or provisionally certified provider's continued compliance with the conditions for certification referred to in 130 CMR 405.405(A), (B), and (C) upon reasonable notice and at any reasonable time during the hours of operation of the provider. The program specialist has the right to revoke the certification or provisional certification of a provider, subject to any applicable provisions of MassHealth regulations in 130 CMR 450.000: *Administrative and Billing Regulations*, if such review reveals that the provider has failed or ceased to meet such conditions.

(2) Any changes in the manager or professional services director or in the scope of services provided by a CHC must be reported in writing to the MassHealth agency's program specialist for CHCs. Any additions to the scope of services must be approved in writing by the program specialist before they are payable by the MassHealth agency. Elimination of services may result in review of the CHC by the MassHealth agency to determine whether the CHC still meets the requirements for certification set forth in 130 CMR 405.405.

405.416: Quality Assessment Program

(A) A CHC must have in effect a program for internal quality assessment that is based on written policies, standards, and procedures, and that includes the following:

(1) a review of the CHC's performance including, but not limited to, adequacy of recordkeeping, referral procedures and follow-up, medication review, quality of patient care, and identification of deficient areas of performance;

(2) recommendations for correcting any deficiencies identified in the review; and

(3) a review of any such corrective action.

(B) These reviews must be conducted at least twice a year by a committee composed of the professional services director, representatives of each professional discipline on the CHC's staff, consumers, and, if possible, health professionals not employed at the CHC. Activities of the committee must be documented in minutes or a report and made available to the MassHealth agency upon request.

405.417: Maximum Allowable Fees

The Executive Office of Health and Human Services (EOHHS) determines the maximum allowable fees for CHC services in accordance with 101 CMR 304.00: *Rates for Community Health Centers*.

405.418: Nonreimbursable Services

(A) MassHealth does not pay a CHC for performing, administering, or dispensing experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments.

(B) MassHealth does not pay a CHC for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay a CHC for the diagnosis of male or female infertility.

(130 CMR 405.419 and 405.420 Reserved)

405.421: Visits: Service Limitations

The following restrictions and limitations apply to visits as defined in 130 CMR 405.402.

(A) Individual Medical Visit. An individual medical visit may not be used for mental health services or for HIV pre- or post-test counseling visits.

(B) Individual Mental Health Visit. An individual mental health visit conducted by a person other than a psychiatrist (for example, a psychologist, nurse, physician assistant, social worker, or counselor) is not reimbursable. An individual mental health visit must be for the sole purpose of examination and diagnosis, and must not include mental health treatment.

(C) Group Clinic Visit. All instructional group sessions for members must be carried out by a physician, nurse practitioner, registered nurse, or physician assistant. A group visit conducted by other kinds of professionals (for example, social workers, counselors, or nutritionists) is not reimbursable as a group clinic visit. These limitations do not apply to group clinic visits for tobacco cessation.

(D) HIV Pre- and Post-Test Counseling Visits. The CHC may be reimbursed for a maximum of two HIV pre-test counseling and two HIV post-test counseling visits per member per test. A maximum of four pre-test counseling visits and four post-test counseling visits per calendar year per member are reimbursable.

(E) Home Visit. A home visit must be used to deliver episodic care in the member's home when a health practitioner has determined that it is not advisable for the member to visit the CHC. The medical record must document the reasons for a home visit. A house-bound member with chronic medical and nursing care needs must be referred to a Medicare-certified home health agency.

(F) Treatments or Procedures. The CHC may bill for a visit, a treatment, or a procedure, but may not bill for more than one of these services provided to the same member on the same date when the services are performed in the same location. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit. Examples of treatments or procedures are a vasectomy or an amniocentesis.

(G) Urgent Care. The MassHealth agency pays an enhanced fee for urgent care when such care is provided at the CHC Monday through Friday from 5:00 P.M. to 6:59 A.M., and from Saturday at 7:00 A.M. through Monday at 6:59 A.M.

405.422: Obstetric Services: Introduction

(A) MassHealth offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available for covered obstetric services. The global-fee method is available only when the conditions in 130 CMR 405.423 are met.

(B) The MassHealth agency will pay for a delivery performed in a hospital by a physician or, in the case of a pelvic delivery, by a nurse midwife who meets the requirements in 130 CMR 405.427 when the physician or nurse midwife is a contractor or employee of the CHC. Such a delivery is covered provided that such a contractor or employee is not receiving a salary from a hospital or other institution to perform the same service. For each such delivery, the CHC may claim payment for the services of only one practitioner (that is, a CHC may not submit two claims for one delivery—one for a physician and one for a nurse midwife).

405.423: Obstetric Services: Global-Fee Method of Payment

(A) Definition of Global Fee. The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The global fee is available only when the conditions in 130 CMR 405.423 are met.

(B) Conditions for Global Fee.

(1) General Requirements. Only the CHC may claim payment of the global fee. To qualify to receive a global fee payment, the CHC must coordinate a minimum of six prenatal visits, the delivery, and postpartum care, provided by a physician, a nurse, a nurse practitioner, a nurse midwife, or a physician assistant who is qualified to perform such services and is a contractor or employee of the CHC. Such an employee or contractor must not be receiving a salary from a hospital or institution to perform the same service. For example, if a staff physician from a hospital performs a delivery while on hospital salary for that service, the CHC must not bill for the global fee for that delivery, but may bill fee for service for the medical visits. However, those visits are not covered if provided by someone receiving a hospital or institutional salary to perform the same service.

(2) Standards of Practice. All the components of a global fee must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

(3) Coordinated Medical Management. The CHC must provide referral to and coordination of the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

(a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;

(b) coordination of medical management with necessary referral to other medical specialties and dental services; and

(c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

(4) Health-Care Counseling. In conjunction with providing prenatal care, the CHC must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:

(a) EPSDT screening for teenage pregnant women;

(b) smoking and substance abuse;

(c) hygiene and nutrition during pregnancy;

(d) care of breasts and plans for infant feeding;

(e) obstetrical anesthesia and analgesia;

(f) the physiology of labor and the delivery process, including detection of signs of early labor;

(g) plans for transportation to the hospital;
(h) plans for assistance in the home during the postpartum period;
(i) plans for pediatric care for the infant; and
(j) family planning.

(5) Obstetrical-Risk Assessment and Monitoring. The CHC must manage the member's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services will be reimbursed separately and should be billed for on a fee-for-service basis. Such services may include, but are not limited to, the following:

(a) counseling specific to high-risk patients (for example, antepartum genetic counseling);
(b) evaluation and testing (for example, amniocentesis); and
(c) specialized care (for example, treatment of premature labor).

(C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.

(1) The global fee may be claimed only by the CHC and only if the required services (minimum of six prenatal visits, the delivery, and postpartum care) are provided directly by a physician, a nurse, a nurse practitioner, a nurse midwife, or a physician assistant who is qualified to perform such services and is a contractor or employee of the CHC.

(2) If the CHC bills for the global fee, any provider who is not a contractor or employee of the CHC, but who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the CHC bills for the global fee, no other provider may claim payment for the delivery.

(3) If the CHC bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same member.

(D) Recordkeeping for Global Fee. The CHC is responsible for documenting, in accordance with 130 CMR 405.412, all the service components of a global fee. This includes services performed by contractors and employees of the CHC. A member's risk assessment and all her medical visits must be recorded in a way that allows for easy review of her obstetrical history. Hospital and ambulatory services must be clearly documented in each member's record.

405.424: Hysterectomy Services

(A) Nonpayable Services. The MassHealth agency does not pay for a hysterectomy provided to a member under the following conditions.

(1) The hysterectomy was performed solely for the purpose of sterilizing the member.

(2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

(B) Hysterectomy Information Form. The MassHealth agency pays for a hysterectomy only when performed by a licensed physician in a hospital, and the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified below.

(1) Prior Acknowledgment. Except under the circumstances specified below, the member and her representative, if any, must be informed orally and in writing before the hysterectomy operation that the hysterectomy will make her permanently incapable of reproducing. (Delivery in hand of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.) Section (B) of the Hysterectomy Information (HI-1) form must be signed and dated by the member or her representative before the operation is performed, as acknowledgment of receipt of this information. Whenever any surgery that includes the possibility of a hysterectomy is scheduled, the member must be informed of the consequences of a hysterectomy, and must sign and date section (B) of the Hysterectomy Information (HI-1) form before surgery.

(2) Prior Sterility. If the member is sterile prior to the hysterectomy operation, the physician who performs the operation must so certify, describe the cause of sterility, and sign and date section (C)(1) of the Hysterectomy Information (HI-1) form.

(3) Emergency Surgery. If the hysterectomy is performed in an emergency, under circumstances that immediately threaten the member's life, and if the physician determines that obtaining the member's prior acknowledgment is not possible, the physician who performs the hysterectomy must so certify, describe the nature of the emergency, and sign and date section (C)(2) of the Hysterectomy Information (HI-1) form.

(4) Retroactive Eligibility. If the hysterectomy was performed during the period of a member's retroactive eligibility, the physician who performed the hysterectomy must certify that one of the following circumstances existed at the time of the operation:

(a) the woman was informed before the operation that the hysterectomy would make her sterile (the physician must sign and date section (D)(1) of the HI-1 form);

(b) the woman was sterile before the hysterectomy was performed (the physician must sign, date, and describe the cause of sterility in section (D)(2) of the HI-1 form); or

(c) the hysterectomy was performed in an emergency that immediately threatened the woman's life and the physician determined that it was not possible to obtain her prior acknowledgment (the physician must sign, date, and describe the nature of the emergency in section (D)(3) of the HI-1 form).

(C) Submission of the Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the MassHealth agency for hysterectomy services. When more than one provider is billing the MassHealth agency for the same hysterectomy, each provider must submit a copy of the completed HI-1 form.

(130 CMR 405.425 Reserved)

405.426: Obstetric Services: Fee-for-Service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by MassHealth. If the global fee requirements in 130 CMR 405.423 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified below.

(A) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(B) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

405.427: Nurse-Midwife Services

(A) Payable Services. The CHC may bill for services provided by a nurse midwife that relate to pregnancy, labor, birth, and the immediate postpartum period when the nurse midwife is a contractor or employee of the CHC. The following conditions also apply.

(1) The services must be limited to the scope of practice authorized by state law or regulation.
(2) The nurse midwife must meet the educational and certification requirements mandated by state law or regulation.
(3) The nurse midwife must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.
(4) The immediate postpartum period during which nurse-midwife services may be provided is defined as a period of time not to exceed six weeks after the date of delivery.
(5) Deliveries by a nurse midwife must occur in facilities licensed by the Department of Public Health for the operation of maternity and newborn services.

(B) Nonpayable Services.

(1) Childbirth education classes are not payable.
(2) Prenatal or postpartum care provided by a nurse midwife in the member's home is not payable.

(C) Educational and Certification Requirements. A nurse midwife on the staff of a CHC must have successfully completed a formal educational program for nurse midwives as required by the Massachusetts Board of Registration in Nursing.

(1) A nurse midwife who has completed such educational requirements may provide services to members before the first certification examination for which the nurse midwife is eligible.
(2) If the scheduled examination is missed, the nurse midwife must immediately cease providing services to members.
(3) Upon receiving notice of failure to pass the examination, the nurse midwife must immediately cease providing services to members.
(4) After passing the examination, the nurse midwife must be certified to practice by the Board of Registration in Nursing.
(5) When such certification expires or is suspended, the nurse midwife must immediately cease providing services to members.

405.428: Sterilization Services: Introduction

(A) Payable Services. The MassHealth agency pays for a sterilization service provided to an eligible member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 405.429, and such consent is documented in the manner and form described in 130 CMR 405.430.

(2) The member is at least 18 years old at the time consent is obtained.

(3) The member is not a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. No provider may use any form of coercion in the provision of sterilization services. No provider, or agent or employee of a provider, may mislead any member into believing that a decision to have or not have a sterilization will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for sterilization services as well as for all other medical serviced covered by MassHealth.

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 405.428(A) are met.

(D) Locations in Which Sterilizations May Be Performed.

(1) Male sterilization must be performed by a licensed physician at the CHC.

(2) Female sterilization must be performed by a licensed physician in a hospital: *Hospital Licensure*.

(3) A hospital in which a sterilization is performed must be licensed in compliance with the Massachusetts Department of Public Health regulations at 105 CMR 130.000: *Hospital Licensure*.

405.429: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 405.429(A) and (B), and such consent is documented as specified in 130 CMR 405.430.

(A) Informed Consent Requirements.

(1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:

(a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member might otherwise be entitled;

(b) a description of available alternative methods of family planning and birth control;
(c) advice that the sterilization procedure is considered irreversible;
(d) a thorough explanation of the specific sterilization procedure to be performed;
(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and
(g) advice that the sterilization will not be performed for at least 30 days from the date consent is given, except under the circumstances specified in 130 CMR 405.429(B)(1).

(2) The person who obtains consent must also
(a) offer to answer any questions the member may have about the sterilization procedure;
(b) give the member a copy of the consent form;
(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 405.429(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;
(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and
(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.
(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 405.429. In the case of a premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is
(a) in labor or childbirth;
(b) seeking to obtain or obtaining an abortion; or
(c) under the influence of alcohol or other substances that affect the individual's state of awareness.
(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 405.429(A)(1).

405.430: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth agency's Consent for Sterilization form in accordance with the following requirements. (Instructions for obtaining the Consent for Sterilization forms are located in Subchapter 5 of the *Community Health Center Manual*.)

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 for members aged 18 through 20; or

(b) CS-21 for members aged 21 and older.

(2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

(B) Required Signatures. The member, the interpreter (if one was required), and the person who obtained the consent for sterilization must all sign and date the Consent for Sterilization form (CS-18 or CS-21) at the time of consent. After performing the sterilization procedure, the physician must sign and date the form.

(C) Required Distribution of the Consent Form. The Consent for Sterilization form (CS-18 or CS-21) must be completed and distributed as follows:

(1) the original must be given to the member at the time of consent; and

(2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed.

(D) Provider Billing and Required Submissions.

(1) All CHCs must bill with the appropriate sterilization diagnosis and service codes, and must attach a copy of the completed Consent for Sterilization Form (CS-18 or CS-21) to each claim made to the MassHealth agency for sterilization services. This provision applies to any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. When more than one provider is billing the MassHealth agency (for example, the CHC and a hospital), each provider must submit a copy of the completed sterilization consent form with the claim.

(2) A CHC does not need to submit a Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim.

(a) The medical procedure, treatment, or operation was a unilateral procedure and did not result in sterilization.

(b) The medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes.

(c) The medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization.

(d) The medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. Include the nature and date of the life-threatening emergency.

(3) In the circumstances set forth in 130 CMR 405.430(D)(2)(a) and (c), the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

(4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 405.430(D)(2), (for example, the CHC and a hospital), each provider must submit a copy of the signed attachment along with the claim.

405.431: Laboratory Services: Introduction

The MassHealth agency only pays CHCs for those laboratory services listed in Subchapter 6 of the *Community Health Center Manual*. The MassHealth agency pays a CHC for laboratory services that are medically necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of MassHealth members, subject to all the restrictions and limitations described in 130 CMR 405.000 and 450.000: *Administrative and Billing Regulations*. In order for a CHC to be paid for any laboratory service, a written request for that service from an authorized prescriber must be present in the member's medical record.

405.432: Laboratory Services: Eligibility to Provide Services

A CHC may claim payment for the laboratory services listed in Subchapter 6 of the *Community Health Center Manual* only when all of the following conditions are met.

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

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

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

(D) If the CHC is located in-state, the CHC has been approved by the Massachusetts Department of Public Health to perform in-house clinical laboratory services. If the CHC is located out-of-state, in addition to meeting the requirements of 130 CMR 405.404(B), 405.432(A) through (C), and 450.109: *Out of State Services*, the CHC must also meet its own state's requirements for performing in-house clinical laboratory services.

405.433: Laboratory Services: Service Limitations

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

(B) The MassHealth agency will not pay a CHC for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the MassHealth agency will pay a CHC that collects, centrifuges, and mails a specimen to an outside laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

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

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

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

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

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

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

405.434: Laboratory Services: Services Performed by Outside Laboratories

(A) Except for the circumstance described in 130 CMR 405.434(C), a CHC may not bill the MassHealth agency for laboratory services provided outside the CHC. In this case, the testing laboratory should bill the MassHealth agency directly for those services.

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

(C) A CHC may bill the MassHealth agency for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(130 CMR 405.435 through 405.440 Reserved)

405.441: Radiology Services: Introduction

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

405.442: Radiology Services: Service Limitations

(A) Definitions.

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

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

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

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

(1) The CHC owns or leases the equipment for providing the technical component of the service, employs a technician to provide the technical component of the service, and employs a board-certified or board-eligible radiologist to provide the professional component of the service.

(2) The CHC employs a board-certified or board-eligible radiologist to provide the professional component of the service and the CHC subcontracts with a licensed Medicare-certified entity to provide the technical component of the service.

(3) The CHC subcontracts with a licensed Medicare-certified entity to provide the professional and technical component of the service.

(C) Subcontracting for Radiology Services.

(1) All subcontracts between the CHC and the licensed Medicare-certified entity must be in writing, ensure continuity of care, and be consistent with all applicable provisions of these regulations.

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

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 405.412), the CHC must keep records of radiology services performed. All X rays must be labeled with the following:

(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

405.443: Radiology Services: Payment Limitations

(A) The maximum allowable fees include payment for both the technical and professional components of the radiology service. A CHC must not bill for either the professional or technical component separately.

(B) Radiology services that are not listed in Subchapter 6 of the *Community Health Center Manual* are not reimbursable when furnished in a CHC. The CHC should refer a member to a hospital for such services.

(C) Some services listed in Subchapter 6 of the *Community Health Center Manual* are designated "S.P.," an abbreviation for separate procedure. Radiology services that are performed at separate sittings on the same or different days are considered separate procedures. The CHC must not bill separately for a service listed as an S.P. service when this service is furnished as a portion of another radiology service at the same sitting.

(D) A CHC must not bill for a visit when a member is being seen for a radiology service only.

(130 CMR 405.444 through 405.450 Reserved)

405.451: Electrocardiogram (EKG) Services: Introduction

The MassHealth agency will pay for an electrocardiogram (EKG) service only when the service is provided at the written request of a CHC staff physician who will interpret or review the interpretation of the EKG. Documentation of the physician's request must be kept in the member's medical record.

405.452: Electrocardiogram (EKG) Services: Eligibility to Provide Services

A CHC may claim payment for electrocardiogram (EKG) services only when both of the following conditions are met.

(A) The CHC owns or rents its own EKG equipment.

(B) The EKG is taken at the CHC or at the member's home.

405.453: Electrocardiogram (EKG) Services: Payment Limitations

(A) The maximum allowable fees include payment for both the technical and professional components of the service. The test must be performed at the CHC and interpreted by a physician employed by the CHC.

(B) A CHC must not bill for a visit when a member is being seen for an EKG only.

(130 CMR 405.454 through 405.460 Reserved)

405.461: Audiology Services: Introduction

In order for a CHC to be paid for an audiology service other than a hearing test performed as part of an EPSDT services assessment (see 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction* through 450.149: *EPSDT Services: Recordkeeping Requirements*), a written request must be made by a physician, nurse practitioner, or physician assistant who has found some indication of a hearing problem. Documentation of the request and of the hearing problem must be kept in the member's medical record.

405.462: Audiology Services: Eligibility to Provide Services

(A) A CHC may claim payment for a basic pure-tone (air and bone) evaluation by audiometer furnished to a member only when the following conditions are met.

(1) The CHC possesses on its premises a pure-tone audiometer, which must be calibrated at least once every six months. Records of calibrations must be kept and made available to the MassHealth agency upon request. The machine must be placed and testing conducted in a quiet room.

(2) The person conducting hearing evaluations is trained to perform hearing tests with an audiometer.

(3) The quality of the tester's work is assessed at least twice a year by an audiologist licensed or certified in accordance with 130 CMR 426.404: *Provider Eligibility* . The audiologist may be a consultant to the CHC.

(B) A CHC may claim payment for conducting acoustic impedance testing only when the following conditions are met.

(1) The test is conducted by an ASLHA-certified audiologist on the premises of the CHC.

(2) The test is conducted by means of a functioning impedance bridge that is placed in a quiet room.

(C) If a problem or abnormality is detected or believed to be present after completion of either the basic pure-tone evaluation or the acoustic impedance test or both, the member must be referred to an otologist or an otolaryngologist for a more complete audiological evaluation and treatment as necessary.

405.463: Audiology Services: Payment Limitations

(A) Audiology services that are not listed in Subchapter 6 of the *Community Health Center Manual* are not reimbursable when furnished in a CHC.

(B) A CHC must not bill for a visit when a member is seen for audiology services only.

(130 CMR 405.464 and 405.465 Reserved)

601 Introduction and Explanation of Abbreviations

MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 405.000 and 450.000: *Administrative and Billing Regulations*. A community health center may request prior authorization (PA) for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age even if it is not designated as covered or payable in Subchapter 6 of the *Community Health Center Manual*.

For complete descriptions of the service codes listed in Subchapter 6, MassHealth providers must refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

The following abbreviations are used in Subchapter 6.

(A) PA indicates that service-specific prior authorization is required (see 130 CMR 450.303).

(B) IC indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim (see 130 CMR 450.271).

(C) SP indicates that the procedure is commonly performed as part of a total service and does not usually warrant a separate fee. The procedure must be performed separately to receive the separate fee.

(D) CS-18 or CS-21 indicates that a completed Sterilization Consent Form (CS-18 for members aged 18 through 20; CS-21 form for members aged 21 and older) must be submitted. See 130 CMR 405.428 through 405.430 for more information.

(E) CS-18* or CS-21* indicates that a completed Sterilization Consent Form (CS-18 for members aged 18 through 20; CS -21 form for members aged 21 and older) must be submitted except if the conditions of 130 CMR 405.430(D)(2) and (3) are met. See 130 CMR 405.428 through 405.430 for more information and other submission requirements.

(F) HI-1: A completed Hysterectomy Information Form must be submitted. See 130 CMR 405.424for more information..

602 Payable Radiology Service Codes

This section lists radiology service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

70030	70220	70355	70482	70546
70100	70240	70360	70486	70547
70110	70250	70370	70487	70548
70120	70260	70371	70488	70549
70130	70300	70373	70490	70551
70134	70310	70380	70491	70552
70140	70320	70390	70492	70553
70150	70328	70450	70540	70554
70160	70330	70460	70542	70555
70190	70332	70470	70543	71010
70200	70336	70480	70544	71015
70210	70350	70481	70545	71020

602 Payable Radiology Service Codes (cont.)

71021	72170	73510	74230	75572
71022	72190	73520	74235	75573
71023	72192	73525	74240	75574
71030	72193	73530	74245	75600
71034	72194	73540	74246	75605
71035	72195	73550	74247	75625
71100	72196	73560	74249	75630
71101	72197	73562	74250	75658
71110	72200	73564	74251	75705
71111	72202	73565	74260	75710
71120	72220	73580	74261 (PA)	75716
71130	72240	73590	74262 (PA)	75726
71550	72255	73592	74270	75731
71551	72265	73600	74280	75733
71555	72270	73610	74283	75736
72010	72275	73615	74290	75741
72020	72285	73620	74291	75743
72040	72291	73630	74300	75746
72050	72292	73650	74301	75756
72052	72295	73660	74305	75774
72069	73000	73700	74320	75791
72070	73010	73701	74327	75801
72072	73020	73702	74330	75803
72074	73030	73718	74340	75805
72080	73040	73719	74355	75807
72090	73050	73720	74400	75809
72100	73060	73721	74410	75810
72110	73070	73722	74415	75820
72114	73080	73723	74420	75822
72120	73085	73725	74425	75825
72125	73090	74000	74430	75827
72126	73092	74010	74440	75831
72127	73100	74020	74445	75833
72128	73110	74022	74450	75840
72129	73115	74150	74455	75842
72130	73120	74160	74470	75860
72131	73130	74170	74475	75870
72132	73140	74174	74480	75872
72133	73200	74176	74485	75880
72141	73201	74177	74710	75885
72142	73202	74178	74740	75887
72146	73218	74181	74742	75889
72147	73219	74182	74775	75891
72148	73220	74183	75557	75893
72149	73221	74185	75559	75898
72156	73222	74190	75561	75901
72157	73223	74210	75563	75902
72158	73500	74220	75565	75945

602 Payable Radiology Service Codes (cont.)

75946	76826	77077	78231	78598
76000	76827	77078	78232	78599 (IC)
76001	76828	77080	78258	78600
76010	76830	77081	78261	78601
76080	76831	77082	78262	78605
76098	76856	77293	78264	78607
76100	76857	77299 (IC)	78270	78608
76101	76870	77399 (IC)	78271	78609
76102	76872	77421	78272	78610
76120	76873	77499 (IC)	78278	78630
76125	76881	77799 (IC)	78282	78635
76376	76882	78012	78290	78645
76377	76885	78013	78291	78647
76380	76886	78014	78299 (IC)	78650
76499 (IC)	76937	78015	78300	78660
76506	76942	78016	78305	78699 (IC)
76510	76945	78018	78306	78700
76511	76946	78020	78315	78701
76512	76948	78070	78320	78707
76513	76950	78071	78350	78708
76514	76965	78072	78399 (IC)	78709
76516	76970	78075	78414	78710
76519	76977	78099 (IC)	78428	78725
76529	76999 (IC)	78102	78445	78730
76536	77001	78103	78451	78740
76604	77002	78104	78452	78761
76645	77003	78110	78453	78799 (IC)
76700	77011	78111	78454	78800
76705	77012	78120	78456	78801
76770	77013	78121	78457	78802
76775	77014	78122	78458	78803
76776	77021	78130	78459	78804
76800	77022	78135	78466	78805
76801	77051	78140	78468	78806
76802	77052	78185	78469	78807
76805	77053	78190	78472	78808
76810	77054	78191	78473	78811
76811	77055	78195	78481	78812
76812	77056	78199 (IC)	78483	78813
76813	77057	78201	78491	78814
76814	77058 (PA)	78202	78492	78815
76815	77059 (PA)	78205	78494	78816
76816	77071	78206	78496	78999 (IC)
76817	77072	78215	78499 (IC)	79999 (IC)
76818	77073	78216	78579	G0202
76820	77074	78226	78580	G0204
76821	77075	78227	78582	G0206
76825	77076	78230	78597	

603 Payable Laboratory Service Codes

This section lists laboratory service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

80047	80194	81050	82172	82438
80048	80195	81099 (IC)	82175	82441
80050	80196	81479 (IC)	82180	82465
80051	80197	81504	82190	82480
80053	80198	82000	82205	82482
80055	80199	82003	82232	82485
80061	80200	82009	82239	82486
80069	80201	82010	82240	82487
80074	80202	82013	82247	82488
80076	80203	82016	82248	82489
80102	80299	82017	82252	82491
80103	80400	82024	82261	82492
80150	80402	82030	82270	82495
80152	80406	82040	82271	82507
80154	80408	82042	82272	82520
80155	80410	82043	82274	82523
80156	80412	82044	82286	82525
80157	80414	82045	82300	82528
80158	80415	82055	82306	82530
80159	80416	82085	82308	82533
80160	80417	82088	82310	82540
80162	80418	82101	82330	82541
80164	80420	82103	82331	82542
80166	80422	82104	82340	82543
80168	80424	82105	82355	82544
80169	80426	82106	82360	82550
80170	80428	82107	82365	82552
80171	80430	82108	82370	82553
80172	80432	82120	82373	82554
80173	80434	82127	82374	82565
80174	80435	82128	82375	82570
80175	80436	82131	82376	82575
80176	80438	82135	82378	82585
80177	80439	82136	82379	82595
80178	80440	82139	82380	82600
80180	81000	82140	82382	82607
80182	81001	82143	82383	82608
80183	81002	82145	82384	82610
80184	81003	82150	82387	82615
80185	81005	82154	82390	82626
80186	81007	82157	82397	82627
80188	81015	82160	82415	82633
80190	81020	82163	82435	82634
80192	81025	82164	82436	82638

603 Payable Laboratory Service Codes (cont.)

82646	82946	83491	83825	84120
82649	82947	83497	83835	84126
82651	82948	83498	83840	84127
82652	82950	83499	83857	84132
82654	82951	83500	83858	84133
82656	82952	83505	83861	84134
82657	82953	83516	83864	84135
82658	82955	83518	83866	84138
82664	82960	83519	83872	84140
82666	82963	83520	83873	84143
82668	82965	83525	83874	84144
82670	82975	83527	83876	84146
82671	82977	83528	83880	84150
82672	82978	83540	83883	84152
82677	82979	83550	83885	84153
82679	82980	83570	83887	84154
82690	82985	83582	83915	84155
82693	83001	83586	83916	84156
82696	83002	83593	83918	84157
82705	83003	83605	83919	84160
82710	83008	83615	83921	84163
82715	83009	83625	83925	84165
82725	83010	83630	83930	84166
82726	83012	83631	83935	84181
82728	83013	83632	83937	84182
82731	83014	83633	83945	84202
82735	83015	83634	83950	84203
82742	83018	83655	83951	84206
82746	83020	83661	83970	84207
82747	83021	83662	83986	84210
82757	83026	83663	83992	84220
82759	83030	83664	83993	84228
82760	83033	83670	84022	84233
82775	83036	83690	84030	84234
82776	83037	83695	84035	84235
82777	83045	83698	84060	84238
82784	83050	83700	84066	84244
82785	83051	83701	84075	84252
82787	83055	83704	84078	84255
82800	83060	83718	84080	84260
82803	83065	83719	84081	84270
82805	83068	83721	84085	84275
82810	83069	83727	84087	84285
82820	83070	83735	84100	84295
82930	83071	83775	84105	84300
82938	83080	83785	84106	84302
82941	83088	83788	84110	84305
82943	83090	83789	84112	84307
82945	83150	83805	84119	84311

603 Payable Laboratory Service Codes (cont.)

84315	84597	85303	85660	86309
84375	84600	85305	85670	86310
84376	84620	85306	85675	86316
84377	84630	85307	85705	86317
84378	84681	85335	85730	86318
84379	84702	85337	85732	86320
84392	84703	85345	85810	86325
84402	84704	85347	85999 (IC)	86327
84403	84999 (IC)	85348	86000	86329
84425	85002	85360	86001	86331
84430	85004	85362	86003	86332
84432	85007	85366	86005	86334
84436	85008	85370	86021	86335
84437	85009	85378	86022	86336
84439	85013	85379	86023	86337
84442	85014	85380	86038	86340
84443	85018	85384	86039	86341
84445	85025	85385	86060	86343
84446	85027	85390	86063	86344
84449	85032	85396	86140	86352
84450	85041	85397	86141	86353
84460	85044	85400	86146	86355
84466	85045	85410	86147	86356
84478	85046	85415	86148	86357
84479	85048	85420	86152	86359
84480	85049	85421	86153 (IC)	86360
84481	85055	85441	86155	86361
84482	85060	85445	86156	86367
84484	85097	85460	86157	86376
84485	85130	85461	86160	86378
84488	85170	85475	86161	86382
84490	85175	85520	86162	86384
84510	85210	85525	86171	86386
84512	85220	85530	86185	86403
84520	85230	85536	86200	86406
84525	85240	85540	86215	86430
84540	85244	85547	86225	86431
84545	85245	85549	86226	86480
84550	85246	85555	86235	86481
84560	85247	85557	86243	86485
84577	85250	85576	86255	86486
84578	85260	85597	86256	86490
84580	85270	85598	86277	86510
84583	85280	85610	86280	86590
84585	85290	85611	86294	86592
84586	85291	85612	86300	86593
84588	85292	85613	86301	86602
84590	85293	85635	86304	86603
84591	85300	85651	86308	86606
	85301	85652		
	85302			

603 Payable Laboratory Service Codes (cont.)

86609	86709	86828	87086	87271
86611	86710	86829	87088	87272
86612	86711	86830	87101	87273
86615	86713	86831	87102	87274
86617	86717	86832	87103	87275
86618	86720	86833	87106	87276
86619	86723	86834	87107	87277
86622	86727	86835	87109	87278
86625	86729	86849 (IC)	87110	87279
86628	86732	86850	87116	87280
86631	86735	86860	87118	87281
86632	86738	86870	87140	87283
86635	86741	86880	87143	87285
86638	86744	86885	87147	87290
86641	86747	86886	87149	87299
86644	86750	86900	87152	87300
86645	86753	86901	87158	87301
86648	86756	86902	87164	87305
86651	86757	86904	87166	87320
86652	86759	86905	87168	87324
86653	86762	86906	87169	87327
86654	86765	86920	87172	87328
86658	86768	86921	87176	87329
86663	86771	86922	87177	87332
86664	86774	86923	87181	87335
86665	86777	86940	87184	87336
86666	86778	86941	87185	87337
86668	86780	86970	87186	87338
86671	86784	86971	87187	87339
86674	86787	86972	87188	87340
86677	86788	86975	87190	87341
86682	86789	86976	87197	87350
86684	86790	86977	87205	87380
86687	86793	86978	87206	87385
86688	86800	86999 (IC)	87207	87389
86689	86803	87001	87209	87390
86692	86804	87003	87210	87391
86694	86805	87015	87220	87400
86695	86806	87040	87230	87420
86696	86807	87045	87250	87425
86698	86808	87046	87252	87427
86701	86812	87070	87253	87430
86702	86813	87071	87254	87449
86703	86816	87073	87255	87450
86704	86817	87075	87260	87451
86705	86821	87076	87265	87470
86706	86822	87077	87267	87471
86707	86825	87081	87269	87472
86708	86826	87084	87270	87475

603 Payable Laboratory Service Codes (cont.)

87476	87555	87999 (PA)(IC)	88262	88399 (IC)
87477	87556	88104	88263	88720
87480	87557	88106	88264	88740
87481	87560	88108	88267	88741
87482	87561	88112	88269	89049
87485	87562	88120	88271	89050
87486	87580	88121	88272	89051
87487	87581	88130	88273	89055
87490	87582	88140	88274	89060
87491	87590	88141	88275	89125
87492	87591	88142	88280	89160
87495	87592	88143	88283	89190
87496	87620	88147	88285	89220 (IC)
87497	87621	88148	88289	89230 (IC)
87498	87622	88150	88291	89240 (IC)
87500	87631	88152	88299 (IC)	89300
87501	87632	88153	88300	89310
87502	87633	88154	88302	89320
87503	87640	88155	88304	93000
87510	87641	88160	88305	93005
87511	87650	88161	88307	93010
87512	87651	88162	88309	93015
87515	87652	88164	88311	93016
87516	87653	88165	88312	93017
87517	87660	88166	88313	93018
87520	87661	86167	88314	93024
87521	87797	88172	88319	93040
87522	87798	88173	88342	93041
87525	87799	88174	88343 (IC)	93042
87526	87800	88175	88346	93224
87527	87801	88177	88347	93225
87528	87802	88182	88348	93226
87529	87803	88184	88349	93227
87530	87804	88185	88355	93228
87531	87807	88187	88356	93229 (IC)
87532	87808	88188	88358	93268
87533	87809	88189	88360	93278
87534	87810	88199 (IC)	88361	93724
87535	87850	88230	88362	93799 (IC)
87536	87880	88233	88363	G0027
87537	87899	88235	88365	G0431
87538	87900	88237	88367	G0434
87539	87901	88239	88368	P9604
87540	87902	88240	88371	
87541	87903	88241	88372	
87542	87904	88245	88380 (IC)	
87550	87905	88248	88381	
87551	87906	88249	88387	
87552	87910	88261	88388	
	87912			

604 Payable Visit and Vaccine Service Codes

This section lists visit and vaccine service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

When claiming payment for visits or vaccines, a CHC must bill according to the following service codes. A visit during which a member sees more than one professional for the same medical problem or general purpose must be claimed as only one visit. (See 130 CMR 405.421 for other requirements.)

(A) The following visit and associated service codes have special requirements or limitations.

Service Code	Modifier	Special Requirement or Limitation
D1206		Covered for children younger than age 21. The CHC may bill for a medical visit in addition to the fluoride varnish application only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.
D9450		Use only for dental enhancement fee. This code may only be billed once per date of service for each member receiving dental services on that date. The dental enhancement fee may not be billed for a fluoride varnish application separately or in addition to a medical visit.
J3490		Use for injectable and infusible drugs and devices supplied in the clinic. Do not use for medications and injectables related to family planning services. (IC)
T1015		Use for individual medical visit.
T1015	HQ	Use for group clinic visit.
90899		Use for individual mental health visit. (IC)
99050		Use for urgent care Monday through Friday from 5:00 P.M. to 6:59 A.M., and Saturday 7:00 A.M. to Monday 6:59 A.M. This code may be billed in addition to the individual medical visit.
99402		Use for HIV counseling visits.

(B) This section lists evaluation and management visit service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

99218	99226	99308	99335	99348
99219	99231	99309	99336	99349
99220	99232	99310	99337	99350 (IC)
99221	99233	99324	99341	99460
99222	99304	99325	99342	99462
99223	99305	99326	99343	
99224	99306	99327	99345 (IC)	
99225	99307	99334	99347	

604 Payable Visit and Vaccine Service Codes (cont.)

The following vaccine administration service codes are payable in addition to the evaluation and management visit service codes in this Section 604(B), provided that the vaccine administration is a medically necessary, separately identifiable service. Under these circumstances, the CHC may append modifier 25 to the evaluation and management visit service code. See MassHealth *All Provider Bulletin 236* for additional information.

90460
90461
90471
90472
90473
90474

(C) The following vaccine service codes have special requirements or limitations.

Service Code	Special Requirement or Limitation
90632	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90636	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90649	Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90650	Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90654	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90655	Only for privately purchased vaccine; vaccine must not otherwise be available free of charge through the Massachusetts Immunization Program.
90656	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90657	Only for privately purchased vaccine; vaccine must not otherwise be available free of charge through the Massachusetts Immunization Program.
90658	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90660	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90661	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90662	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90664	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90666	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Special Requirement or Limitation
90667	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90668	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90670	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90672	Covered for members aged 19 to 49; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90673	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90686	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90688	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90707	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90713	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90714	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90715	Covered for adults ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90716	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90732	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90733	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.
90734	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90736	(IC); PA is required for members < age 50.
90746	Covered for adults ≥19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.

605 Payable Obstetrics Service Codes

This section lists obstetrics service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

See 130 CMR 405.422 through 405.426 for other requirements.

(A) Fee-for-Service Deliveries

59409
59410
59414
59514
59515
59525 (HI-1 form required)
59612
59614
59620
59622

(B) Global Deliveries

59400
59510
59610
59618

606 Payable Surgery Service Codes

This section lists surgery service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

44955
49255
49320
54057
54150
54160
55250 (CS-18 or CS-21 required) (SP)
55450 (CS-18 or CS-21 required) (SP)
56420
56440
57240
57250
57260
57520
57522
57700
58120
58140
58146
58150 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58180 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58353
58541 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58542 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58543 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58544 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58555
58558
58560
58561
58600 (CS-18 or CS-21 required)
58605 (CS-18 or CS-21 required) (SP)
58611 (CS-18 or CS-21 required)
58615 (CS-18 or CS-21 required)
58660
58661 (CS-18* or CS-21* required; PA for Gender Dysphoria-Related Services Only)
58670 (CS-18 or CS-21 required)
58671 (CS-18 or CS-21 required)
58700
58720 (CS-18* or CS-21* required; PA for Gender Dysphoria-Related Services Only)
58940
59000
59012
59015
59025
59870

607 Payable Nurse-Midwife Service Codes

This section lists nurse-midwife service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

See 130 CMR 405.427 for requirements. When billing for delivery services performed by a nurse midwife, the provider must use a modifier.

Service Code	Modifier	Special Requirement or Limitation
T1015	TH	Use for a medical visit with a nurse midwife for a prenatal or postpartum service.
59400		
59409		
59410		
59414		
59610		
59612		
59614		

608 Payable Audiology Service Codes

This section lists audiology service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

See 130 CMR 405.461 through 405.463 for other requirements.

92551
92552
92553
92567

609 Payable Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Health Assessment Service Codes

This section lists Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Health Assessment service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

See 130 CMR 450.140 through 450.149 for other requirements.

99381	99383	99385	99392	99394
99382	99384	99391	99393	99395

610 Payable Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Audiometric Hearing and Vision Test Service Codes

This section lists Early and Periodic Screening, Diagnosis and Treatment (EPSDT): Audiometric Hearing and Vision Test service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

92551
92552
92587
99173

611 Payable Tobacco Cessation Service Codes

This section lists tobacco cessation service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

Service Code	Modifier	Special Requirement or Limitation
99407		at least 30 minutes; eligible providers are physicians employed by community health centers.
99407	HN	at least 30 minutes; eligible providers are physician assistants employed by community health centers.
99407	HQ	for an individual in a group setting, 60-90 minutes; eligible providers are physicians employed by community health centers.
99407	SA	at least 30 minutes; eligible providers are nurse practitioners employed by community health centers.
99407	SB	at least 30 minutes; eligible providers are nurse midwives employed by community health centers.
99407	TD	at least 30 minutes; eligible providers are registered nurses employed by community health centers.
99407	TF	intake assessment for an individual, at least 45 minutes; eligible providers are physicians employed by community health centers.
99407	U1	at least 30 minutes; eligible providers are tobacco cessation counselors employed by community health centers.
99407	U2	intake assessment for an individual, at least 45 minutes; eligible providers are nurse practitioner, nurse midwife, physician assistant, registered nurse, and tobacco cessation counselor.
99407	U3	for an individual in a group setting, 60-90 minutes; eligible providers are nurse practitioners, nurse midwives, physician assistants, registered nurses, and tobacco cessation counselors.

612 Payable Medical Nutrition Therapy and Diabetes Self-Management Training Service Codes

This section lists medical nutrition therapy and diabetes self-management training service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book and to the HCPCS Level II code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

G0108
G0109
G0270
G0271
97802
97803
97804

613 Payable Behavioral Health Screening Tool Service Codes

This section lists behavioral health screening tool service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

The administration and scoring of standardized behavioral-health screening tools selected from the approved menu of tools found in Appendix W of your MassHealth provider manual is covered for members (except MassHealth Limited) from birth to 21 years of age.

Service Code	Modifier	Special Requirement or Limitation
96110	U1	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; with no behavioral health need identified* (Eligible providers are physicians employed by community health centers.)
96110	U2	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; and behavioral health need identified* (Eligible providers are physicians employed by community health centers.)
96110	U3	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; with no behavioral health need identified* (Eligible providers are nurse midwives employed by community health centers.)
96110	U4	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; and behavioral health need identified* (Eligible providers are nurse midwives employed by community health centers.)
96110	U5	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; with no behavioral health need identified* (Eligible providers are nurse practitioners employed by community health centers.)

613 Payable Behavioral Health Screening Tool Service Codes (cont.)

Service Code	Modifier	Special Requirement or Limitation
96110	U6	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; and behavioral health need identified* (Eligible providers are nurse practitioners employed by community health centers.)
96110	U7	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; with no behavioral health need identified* (Eligible providers are physician assistants employed by community health centers.)
96110	U8	Covered for members birth to 21 for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your MassHealth provider manual; and behavioral health need identified* (Eligible providers are physician assistants employed by community health centers.)

** "Behavioral health need identified" means the provider administering the screening tool, in his or her professional judgment, identifies a child with a potential behavioral health services need.*

614 Payable Acupuncture Service Codes

This section lists acupuncture service codes that are payable under MassHealth. For complete descriptions of the service codes listed, refer to the American Medical Association's latest *Current Procedural Terminology (CPT)* code book (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

97810
97811
97813
97814

615 Modifiers

The following service code modifiers are allowed for billing under MassHealth.

Modifier	Description
24	Unrelated evaluation and management service by the same physician during postoperative period.
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service
26	Professional Component
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only

615 Modifiers (cont.)

Modifier	Description
57	Decision for Surgery
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period.
59	Distinct procedural service.
62	Two surgeons
66	Surgical team
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period.
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.
80	Assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
91	Repeat clinical diagnostic laboratory test.
99	Multiple modifiers
LT	Left side (used to identify procedures performed on the left side of the body).
RT	Right side (used to identify procedures performed on the right side of the body).
TC	Technical Component

The following modifiers are for Provider Preventable Conditions that are National Coverage Determinations

Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see Appendix V of your provider manual.

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