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

MassHealth
Transmittal Letter CHC-112
June 2019

TO: Community Health Centers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: *Community Health Center Manual* (Updates to 130 CMR 405.000 and Subchapter 6)

Updates to 130 CMR 405.000 (Subchapter 4)

This letter transmits revisions to the MassHealth Community Health Center Services regulations at 130 CMR 405.000. These regulations have been amended to allow Community Health Centers (CHCs) to provide chiropractor services on site or by referral. The regulations have also been updated to allow for a mental health visit where examination, diagnosis and treatment can be provided at the CHC; to clarify other CHC service definitions and limitations; and to clarify requirements for services provided on site, at satellite clinics, and by referral.

Updates to Subchapter 6

This letter also transmits revisions to the service codes contained in Subchapter 6 of the *Community Health Center Manual*, as described below.

HCPCS Updates

The Centers for Medicare & Medicaid Services (CMS) has revised the Healthcare Common Procedure Coding System (HCPCS) codes for 2019. This letter transmits the updated codes. For dates of service on or after January 1, 2019, CHCs must use the updated codes in order to obtain payment.

New Codes

A4261	J7301	49084	57456	58562
A4266	J7303	54050	57460	58565
A4267	J7304	56501	57461	76978
A4268	J7307	56515	57500	76979
A4269	S4989	56605	57505	76981
G0469	S4993	57061	57510	76982
G0470	11976	57100	57511	76983
J1050	11981	57420	57513	77046
J3490 FP	11982	57421	57800	77047
J7296	11983	57425	58100	77048
J7297	19100	57452	58300	77049
J7298	49082	57454	58301	81163
J7300	49083	57455	58340	81164

81165	82642	96130
81166	83722	96132

Deleted Codes

76001	77059	78271	90792
77058	78270	78272	99213

Telehealth Services

Effective January 1, 2019, in accordance with All Provider Bulletin 281 (available at www.mass.gov/lists/all-provider-bulletins), CHCs may bill for the following behavioral health services provided via telehealth. This letter transmits these updates. CHCs must include the Place of Service (POS) Code 02 when submitting a claim for covered services delivered via telehealth.

G0469	90836
G0470	90837
90791	90853
90832	90882
90834	

Rates

Rates for CHCs participating in MassHealth are set by regulation by the Executive Office of Health and Human Services and available at www.mass.gov/service-details/eohhs-regulations. Applicable rate regulations for CHCs include: 101 CMR 304.00: *Community Health Center Services*; 101 CMR 317.00: *Medicine*; 101 CMR 316.00: *Surgery and Anesthesia Services*; 101 CMR 318.00: *Radiology*; 101 CMR 306: *Mental Health Services*; 101 CMR 314.00: *Dental Service*; and 101 CMR 320.00: *Clinical Laboratory Services*.

MassHealth Website

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

To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

If you have any questions about this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, email 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, iv-a, vi, 4-1 through 4-36, and 6-1 through 6-22

OBSOLETE MATERIAL

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

Community Health Center Manual

Pages iv, vi, 4-1 through 4-4, and 4-11 through 4-24 — transmitted by Transmittal Letter 102
Pages iv-a, and 4-25 through 4-26 — transmitted by Transmittal Letter 107
Pages 4-5 through 4-10 — transmitted by Transmittal Letter 57
Pages 6-1 through 6-18 — transmitted by Transmittal Letter 111

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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 130 CMR 405.000 and 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 Law 102-585, the Veterans Health Act of 1992.

340B Drug-pricing Program — a program established by Section 340B of Public 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.

Family Therapy — a session for simultaneous treatment of two or more members of a family.

Freestanding Clinic — any institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 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, certified nurse practitioner, clinical nurse specialist, 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.

Group Therapy — application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

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 Post-test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, 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.

HIV Pre-test Counseling Visit — a face-to-face meeting at the CHC between the member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, 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.

Home Visit — a face-to-face meeting between a member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, 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, certified nurse practitioner, clinical nurse specialist, 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, certified nurse practitioner, clinical nurse specialist, or registered nurse for medical examination, diagnosis, or treatment.

Individual Mental Health Visit —a face-to-face meeting at the CHC between a patient and either a psychiatrist or an advanced practice registered nurse (APRN) with a graduate degree and advanced training in psychiatric care (a psychiatric clinical nurse specialist or a psychiatric mental health nurse practitioner) within the community health center setting, for purposes of examination, diagnosis, or treatment.

Individual Therapy — psychotherapeutic services provided to an individual.

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, certified nurse practitioner, clinical nurse specialist, 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.

Psychological Testing — the use of standardized test instruments to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology.

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, 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 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 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 130 CMR 405.405(B) except for one or more of the following: 130 CMR 405.408(F): *Nutrition Services*, 405.408(C): *Obstetrics/Gynecology*, 405.414: *Translation Services*, or 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 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) through (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 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.

405.406: Administrative Requirements

A CHC must meet the administrative requirements specified in 130 CMR 405.406 to receive certification as outlined in 130 CMR 405.405.

(A) Licensing. The CHC must be licensed as a clinic by the Massachusetts Department of Public Health. For the purposes of 130 CMR 405.000, the term "licensee" means the entity named in the license issued by the Department of Public Health. A CHC can be comprised of multiple sites that are identified on the license as "satellites." Services provided at satellites are considered to be provided on site.

(B) Nonprofit Status. The CHC must be a nonprofit organization.

(C) Staffing.

(1) The CHC must employ an on-site manager who is qualified by education, training, or experience to serve as the administrator of the CHC. The manager is responsible to the licensee for both the management and administration of CHC services, for carrying out policies established or approved by the licensee, and for ensuring that the CHC complies with 130 CMR 405.000.

(2) The CHC must employ a professional services director who is a health practitioner qualified by education, training, or experience to direct and evaluate the provision of health services in the CHC. The professional services director must supervise the staff members providing health services and must ensure that treatment and care are both adequate and appropriate to the needs of members and are in compliance with 130 CMR 405.000. The professional services director must be either on site or on call at all times that the CHC is in operation.

(3) The same individual may serve as both the manager and the professional services director, if this individual meets the requirements in 130 CMR 405.406(C)(1) and (2).

(D) Minimum Hours. The CHC must be open for the delivery of medical services to the public on a regular schedule for a minimum of 20 hours per week. The schedule must be arranged to afford maximum access to members, such as by regularly scheduled evening or weekend clinic hours.

(E) Governing Board. The CHC must have a governing or advisory board that includes at least one person who regularly uses the services of the CHC. This person may not be employed by the CHC or the licensee while a member of the board. Matters subject to review by the board must include, but are not necessarily limited to, scope of services, budget, personnel policies, and program evaluation.

(F) Member Grievances. The CHC must have established written procedures for accepting, processing, and responding to member grievances.

405.407: Physician Time Required on Site

Except as specified in 130 CMR 405.407(A) and (B), a CHC must have at least one licensed physician on site during its hours of operation to treat medical problems outside the expertise of other health practitioners on the CHC's staff. This physician may leave the CHC for limited periods to visit CHC patients in their homes, in hospitals, or in nursing facilities; but he or she must be on call to the CHC during such periods.

(A) CHCs that are located in isolated rural areas where no licensed physician is available on a regular basis within a 20-mile radius and that have a licensed physician on call during all hours of operation may apply to the MassHealth agency's Program Specialist for community health centers for a waiver of this requirement.

(B) CHCs that employ family practitioners on site may substitute family practitioners for other specialists who are unavailable due to the center's geographic isolation, but whose specialized services must be provided on site. These specialties include pediatrics, obstetrics/gynecology, and internal medicine.

405.408: Medical Services Required on Site

A CHC must provide on site the medical services specified in 130 CMR 405.408. It is not necessary that all of these services be available during all hours of the CHC's operation, but all must be available to members on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care. If the CHC does not serve patients of a particular age group, upon the prior written approval of the MassHealth agency, the CHC will not be required to provide pediatric or obstetrical/gynecological services or both (*see* 130 CMR 405.408(A) and (C)).

(A) Pediatric Services. A CHC must provide pediatric services.

(B) Internal Medicine. A CHC must provide internal medicine services.

(C) Obstetrics/Gynecology. A CHC must provide obstetrical and gynecological services. When a family practitioner is employed in place of a specialist in obstetrics/gynecology, the family practitioner must have admitting privileges to a hospital for delivery and obstetrical and gynecological backup.

(D) Health Education. A CHC must provide health education designed to prepare members for their participation in and reaction to specific medical procedures, and to instruct members in self-management of medical problems and in disease prevention. Health education may be provided by any health practitioner or by any other individual approved by the professional services director as possessing the qualifications and training necessary to provide health education to members.

(E) Medical Social Services. A CHC must provide medical social services designed to assist members in their adjustment to and management of social problems resulting from medical treatment, specific disease episodes, or chronic illness. Medical social services must be provided by a clinical social worker who is licensed by the Massachusetts Board of Registration. This individual must be on site sufficient hours and with sufficient frequency to provide medical social services to members.

(F) Nutrition Services. A CHC must provide counseling in the purchase, preparation, and consumption of proper nutrients to members who have been determined to require such counseling because of their health problems or because they have a high potential for developing health problems that might be avoided or made less severe through proper nutrition. Each CHC must employ either a nutrition professional with a bachelor's or master's degree in public health nutrition, community nutrition, or human nutrition; or a dietitian who is currently registered by the Academy of Nutrition and Dietetics. This individual is responsible for planning, directing, and evaluating the nutrition services provided at the CHC; for educating the CHC's staff about nutrition; for supervising any nutrition aides; for consulting with practitioners and other staff members of the CHC; and for counseling members referred for nutrition information. The nutrition professional or registered dietitian must be on site at least one day per calendar month.

405.409: Medical Services Required on Site or by Referral

All of the services listed in 130 CMR 405.409 must be provided on site or, alternatively, through a referral network. For the purpose of 130 CMR 405.409, a service furnished by a practitioner other than an employee or contractor of the CHC for which the practitioner, rather than the CHC, claims payment is not considered to be "on site," even if the service is provided on CHC premises. With the exception of audiology, electrocardiogram, laboratory, and radiology services, the CHC must notify the MassHealth agency, in writing, of each service listed in 130 CMR 405.409(A) through (N) that the CHC will provide on site. All services provided on site must be furnished by practitioners qualified to provide the service that are employees or contractors of the CHC. With the exceptions of audiology, electrocardiogram, laboratory, and radiology services provided on site (for which such services must be furnished and payment claimed by the CHC in accordance with applicable provisions set forth in 130 CMR 405.000 and Subchapter 6 of the *Community Health Center Manual*), all services set forth below that are provided on site must be furnished, and associated payment claimed by the CHC, in compliance with the applicable MassHealth regulations and subchapter 6 for each such service, including applicable fee schedules. All services listed in 130 CMR 405.409(A) through (N) that are provided by referral must be based on written agreements between the CHC and each referral provider to ensure continuity of care, exchange of relevant health information such as test results and records, and avoidance of service duplication. Each referral provider must be a participating provider in MassHealth, and payment for the services provided by the referral provider must be claimed by the referral provider in compliance with the applicable MassHealth regulations for such service. All referrals must include follow-up to ensure that the referral process is successfully completed. Services that must be provided on site or through the referral network are the following:

(A) audiology services;

(B) chiropractor services;

(C) dental services;

(D) electrocardiogram (EKG) services;

(E) laboratory services;

(F) medical specialty services such as, but not limited to, cardiology and neurology;

(G) mental health services, including psychological testing;

(H) occupational therapy services;

(I) pharmacy services;

(J) physical therapy services;

(K) podiatry services;

(L) radiology services;

(M) speech/language therapy services; and

(N) vision care services.

(130 CMR 405.410 Reserved)

405.411: Continuity of Care

A CHC must maintain continuity of care in providing health services to members. Continuity of care ensures that a member will always be seen by a health practitioner knowledgeable about the member's case. Mere access to medical records by all practitioners who deliver services to a member will not suffice as a means of complying with 130 CMR 405.411.

405.412: Record-keeping Requirements

(A) A CHC must comply with the MassHealth agency's record-keeping regulation contained in 130 CMR 450.000: *Administrative and Billing Regulations*. In addition, each member's medical record must include the reason for each visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, a medical record must include, but not be limited to:

(1) the date of each service;
(2) the member's name and date of birth;
(3) the signature and title of the person performing the services;
(4) the member's medical history;
(5) the diagnosis or chief complaint;
(6) clear indication of all findings, whether positive or negative, on examination;
(7) any medications administered or prescribed, including strength, dosage, and regimen;
(8) a description of any treatment given;
(9) recommendations for additional treatments or consultations, when applicable;
(10) any medical goods or supplies dispensed or prescribed;
(11) any tests administered and their results;
(12) a notation of hospitalization ordered by a CHC practitioner and discharge summaries from such hospitalization; and
(13) notations of all referrals and results of referrals, including the referral provider's diagnoses, treatment plans, test results, and medical outcomes.

(B) Basic data collected during previous visits (for example, identifying data, chief complaint, and history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care furnished to a member must be included for each service for which payment is claimed, along with any data that update the member's medical course. It is not necessary to include a full medical history in the medical record for any member who is seen by the CHC on a one-time emergency basis.

(C) For hospital visit services, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit for which payment is claimed. An inpatient medical record documents services provided to members and billed to the MassHealth agency if it conforms to and satisfies the medical records requirements set forth in the current Rules and Regulations for Hospitals in Massachusetts issued by the Massachusetts Department of Public Health. The CHC claiming payment for a hospital inpatient visit is responsible for the adequacy of the medical record documenting such visit. The physician must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(D) Additional medical records requirements for other services can be found in the applicable sections of the MassHealth agency's regulations.

405.413: Coordination of Services

A CHC that provides any of the services listed in 130 CMR 405.409 or 405.471 must coordinate these services with all other services at the CHC. Such coordination includes at a minimum:

(A) one central medical record for each member in which all health care services are recorded;

(B) medical accountability to the CHC's professional services director;

(C) administrative accountability to the CHC's manager;

(D) participation in the CHC's quality assessment program (if the special group of services has its own plan for quality assessment, this plan must be approved by the professional services director who must also receive progress reports);

(E) regular participation in the CHC's staff meetings and other appropriate activities by those professionals responsible for directing special services; and

(F) familiarity with the CHC's policies, procedures, staff, and scope of services by all personnel employed through special programs.

405.414: Translation Services

A CHC must employ at least one practitioner or translator conversant in the primary language of each substantial population (10% or more of the total member population) of non-English-speaking members that regularly uses the CHC.

405.415: Emergency Backup Services

(A) A CHC must provide either:
(1) 24-hour-a-day on-site medical or emergency services or both; or
(2) an after-hours telephone service, and have a written agreement with a provider of 24-hour-a-day medical or emergency service or both.

(B) A tape-recorded telephone message instructing members to call an emergency backup provider or a hospital emergency room does not suffice as compliance with the requirement of 130 CMR 405.415(A).

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 record-keeping, 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 payment rate for CHC services in accordance with 101 CMR 304.00: *Rates for Community Health Centers*. For services payable to CHCs for which the maximum allowable fee is not listed in 101 CMR 304.00, EOHHS determines the payment rates in accordance with the applicable EOHHS pricing regulations that govern payment of those services.

Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 405.000.

405.418: Nonreimbursable Services

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

(B) The MassHealth agency 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, including family planning, may not be for an individual mental health service 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 or an advanced practice registered nurse (APRN) with a graduate degree and advanced training in psychiatric care (a psychiatric clinical nurse specialist or a psychiatric mental health nurse practitioner) is not reimbursable. Other mental health services provided by qualified clinicians and properly billed are reimbursable, but not as Individual Mental Health Visits.

(C) Group Clinic Visit. All instructional group sessions for members must be carried out by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse. 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, colposcopy, or an amniocentesis. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit.

(G) Immunization or Injection.

(1) The CHC may bill for either an office visit or vaccine administration, but may not bill for both an office visit and vaccine administration for the same member on the same date when the office visit and the vaccine administration are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the vaccine was administered.

(2) The MassHealth agency pays for the cost of the injectable material unless the Massachusetts Department of Public Health distributes the injectable material free of charge.

(H) 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.

(I) Individual Psychotherapy. The MassHealth agency pays for psychotherapeutic services provided to an individual member.

(J) Family and Couple Therapy. The MassHealth agency pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one fee per session, regardless of the number of family members present or the presence of a cotherapist.

(K) Group Therapy.
(1) Payment is limited to one fee per group member with a maximum of 12 members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(L) Multiple-family Group Therapy.
(1) Payment is limited to one fee per group member with a maximum of ten members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for multiple-family group psychotherapy when it is performed as an integral part of a psychiatric day treatment program.

(M) Diagnostic Services. The MassHealth agency pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(N) Psychological Testing. The MassHealth agency pays for psychological testing only when provided by a licensed psychologist who either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.

405.422: Obstetric Services: Introduction

(A) The MassHealth agency 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 certified nurse midwife who meets the requirements in 130 CMR 405.427 when the physician or certified 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 certified 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 certified nurse practitioner, a certified 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 certified nurse practitioner, a certified 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) Record-keeping 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 in 130 CMR 405.424(B)(1) through (4).

(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 in 130 CM 405(A) and (B).

(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: Certified Nurse-midwife Services

(A) Payable Services. The CHC may bill for services provided by a certified 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 certified nurse midwife must meet the educational and certification requirements mandated by state law or regulation.
(3) The certified 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 certified 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 certified 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 certified nurse midwife in the member's home is not payable.

(C) Educational and Certification Requirements. A certified nurse midwife on the staff of a CHC must have successfully completed a formal educational program for certified 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 certified 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.

(3) A hospital in which a sterilization is performed must be licensed in compliance with 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 18 through 20 years of age; or

(b) CS-21 for members 21 years of age 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 accordance 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).

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

(1) tests performed to establish paternity;

(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and

(3) post-mortem examinations.

(F) Some services listed in Subchapter 6 of the *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.

(G) 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) 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.

(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.

For radiology services furnished as part of a chiropractor service provided on site at the CHC, such radiology services must be furnished and payment claimed by the CHC in compliance with the MassHealth Chiropractor regulations at 130 CMR 441.000: *Chiropractor Services*, including applicable radiology fee schedules and Subchapter 6 of the *Chiropractor Manual*.

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 130 CMR 405.000.

(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. 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 through 450.149), a written request must be made by a physician, physician assistant, or certified nurse practitioner 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)

405.466: Pharmacy Services: Participation in the 340B Drug-pricing Program for Outpatient CHC Pharmacies

(A) Notification of Participation. A CHC that is a 340B-covered entity may provide drugs to MassHealth members through the 340B drug-pricing program provided that it notifies the MassHealth agency in writing that the 340B-covered entity is registered and approved by the federal Office of Pharmacy Affairs (OPA).

(B) Subcontracting for 340B Outpatient CHC Pharmacy Services.

(1) A CHC that is a 340B-covered entity may contract with a MassHealth pharmacy provider to dispense 340B drugs for the 340B-covered entity's MassHealth patients. All such subcontracts between the 340B-covered entity and a pharmacy provider must be in writing, ensure continuity of care, specify that the CHC pays the pharmacy, specify that such payment constitutes payment in full for 340B drugs provided to MassHealth members, be consistent with all applicable provisions of 130 CMR 406.000: *Pharmacy Services*, and are subject to approval by the MassHealth agency.

(2) The CHC is legally responsible to MassHealth for the performance of any subcontractor. The CHC must ensure that every pharmacy subcontractor is licensed by the Massachusetts Board of Registration in Pharmacy, and is a MassHealth pharmacy provider, and that services are furnished in accordance with 130 CMR 406.000: *Pharmacy Services* and all other applicable MassHealth requirements including, but not limited to, those set forth in 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Termination or Changes in 340B Drug-pricing Program Participation. A CHC must provide the MassHealth agency 30 days advance written notice of its intent to discontinue, or change in any way material to MassHealth, the manner in which it provides 340B outpatient drugs for its MassHealth patients.

(D) Payment for 340B Outpatient CHC Pharmacy Services. MassHealth pays the 340B-covered entity for outpatient CHC pharmacy services, whether provided and billed directly or through a subcontractor, at the rates established in 101 CMR 331.00: *Prescribed Drugs*.

405.467: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary community health care for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 405.000, and with prior authorization.

405.468: Drugs Administered in the CHC (Provider-administered Drugs)

(A) Drugs and biologicals dispensed in the CHC are payable, subject to the exclusions and service limitations at 130 CMR 405.417, 405.418, and 130 CMR 406.413(B): *Drug Exclusions* and (C): *Service Limitations*.

(B) The MassHealth agency does not pay separately for drugs that are considered routine and integral to the delivery of a service in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the CHC's fee for the service.

(C) The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the CHC has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization.

(D) Claims for drugs and biologicals that are listed in Subchapter 6 of the *Community Health Center Manual* must include the name of the drug or biological, strength, dosage, and number of Healthcare Common Procedure Coding System (HCPCS) units dispensed, National Drug Code (NDC), NDC units, and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Community Health Center Manual*, a copy of the invoice showing the actual acquisition cost must be attached to the claim. Claims without this information are denied.

(E) The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with 101 CMR 331.00: *Prescribed Drugs.*

(F) The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.

(G) Payment for drugs may be claimed in addition to an office visit.

(130 CMR 405.469 through 405.470 Reserved)

405.471: Optional Reimbursable Services

A CHC may elect to provide the following services on site or by referral, but it is not required to do so under 130 CMR 405.000. The CHC must notify the MassHealth agency in writing of each service listed in 130 CMR 405.471(A) through (E) that the CHC will provide on site and must enroll with MassHealth as that provider type. All services provided on site must be furnished by practitioners qualified to provide the service that are employees or contactors of the CHC, and associated payment claimed by the CHC, in compliance with the applicable MassHealth regulations and Subchapter 6 for each service, including applicable fee schedules. All services listed below that are provided by referral must be based on written agreements between the CHC and each referral provider to ensure continuity of care, exchange of relevant health information such as test results and records, and avoidance of service duplication. Each referral provider must be a participating provider in MassHealth, and payment for the services provided by the referral provider must be claimed by the referral provider in compliance with the applicable MassHealth regulations for such service. All referrals must include follow up to ensure that the referral process is successfully completed. Services the CHC may elect to provide include:

(A) adult day health services;

(B) adult foster care;

(C) day habilitation;

(D) psychiatric day treatment; and

(E) home health services.

405.472: Tobacco-cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 405.472(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000*: Pharmacy Services*.

(B) Tobacco-cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco-cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco-cessation services as set forth in 130 CMR 405.472(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members, and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other healthcare providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco-cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including:

1. a review of the health consequences of tobacco use and the benefits of quitting;
2. a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and
3. a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

1. identification of personal risk factors for relapse and incorporation into the treatment plan;
2. strategies and coping skills to reduce relapse risk; and
3. a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

1. the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and
2.) the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco-cessation Counseling Services.

(1) Qualified Personnel.

(a) Physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants may provide tobacco-cessation counseling services without additional experience or training in tobacco-cessation counseling services.

(b) All other providers of tobacco-cessation counseling services must be under the supervision of a physician, and must complete a course of training in tobacco-cessation counseling by a degree-granting institution of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco-cessation Counseling Services. A physician must supervise all nonphysician providers of tobacco-cessation counseling services.

(D) Tobacco-cessation Services: Claims Submission. A CHC may submit claims for tobacco-cessation counseling services that are provided by physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists and physician assistants, and MassHealth-qualified tobacco-cessation counselors according to 130 CMR 405.472(B) and (C). *See* Subchapter 6 of the *Community Health Center Manual* for service codes.

405.473: Fluoride Varnish Services

(A) Eligible Members. Members must be younger than 21 years old to be eligible for the application of fluoride varnish.

(B) Qualified Personnel. Physicians, physician assistants, certified nurse practitioners, registered nurses, licensed practical nurses, and medical assistants may apply fluoride varnish subject to the limitation of state law. To qualify to apply fluoride varnish, the individual must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of the training, and provide such proof to the MassHealth agency upon request.

(C) Billing for a Medical Visit and Fluoride Varnish Treatment or Procedure. A CHC may bill for fluoride varnish services provided by a physician or a qualified staff member as listed in 130 CMR 405.473(B) under the supervision of a physician. 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. The dental enhancement fee may not be billed for a fluoride varnish application separately or in addition to a medical visit.

(D) Claims Submission. A CHC may submit claims for fluoride varnish services that are provided by physicians, physician assistants, certified nurse practitioners, registered nurses, licensed practical nurses, and medical assistants according to 130 CMR 405.473(C). *See* Subchapter 6 of the *Community Health Center Manual* for service codes.

405.474: Acupuncture Services

(A) Introduction. MassHealth members are eligible to receive acupuncture services in CHCs for the treatment of pain as described in 130 CMR 405.474(C). *See* 130 CMR 433.454(E): *Acupuncture as an Anesthetic* for use of acupuncture as an anesthetic, and 130 CMR 418.000: *Substance Use Disorder Treatment Services* for use of acupuncture for detoxification.

(B) General. 130 CMR 405.474 applies specifically to physicians and other licensed practitioners of acupuncture in a CHC. The requirements elsewhere in 130 CMR 405.000 that apply to a CHC, also apply to licensed practitioners of acupuncture, such as service limitations, record-keeping, report requirements, and prior-authorization requirements.

(C) Acupuncture for the Treatment of Pain. MassHealth provides a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may be able to receive more sessions of medically-necessary acupuncture treatment with prior authorization.

(D) Provider Qualifications for Acupuncture.
(1) Qualified Providers.
(a) Physicians
(b) Other providers who are licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: *The Practice of Acupuncture*.
(2) Acupuncture Providers in CHCs. CHCs must ensure that acupuncture providers for whom the CHC will submit claims possess the appropriate training, credentials, and licensure.

(E) Conditions of Payment. The MassHealth agency pays the CHC for services of an acupuncturist (in accordance with 130 CMR 405.474(F)) when the:

(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 243 CMR 5.00: *The Practice of Acupuncture*);

(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and

(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.

(1) Community health centers (CHCs) may submit claims for acupuncture services when they are provided to MassHealth members by physicians or when a licensed provider under the supervision of a physician provides those services directly to MassHealth members. *See* Subchapter 6 of the *Community Health Center Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the CHC may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same CHC on the same day of the acupuncture service.

405.475: Medical Nutrition Therapy

(A) Introduction. MassHealth members are eligible to receive medical nutrition therapy services described in 130 CMR 405.475(B). *See* Subchapter 6 of the *Community Health Center Manual* for service code descriptions and billing requirements.

(B) The MassHealth agency pays for nutritional diagnostic therapy and counseling services for the purpose of management of a medical condition. Medical nutrition therapy services are payable when provided to eligible MassHealth members by the following providers:

(1) physicians;

(2) dietitians/nutritionists licensed by the Massachusetts Division of Professional licensure, and the Board of Registration of Dietitians and Nutritionists;

(3) mid-level practitioners credentialed by the Commission on Dietetic Registration (CDR) (*e.g.*, certified nurse-midwives, certified nurse practitioners, registered nurses, and physician assistants); or

(4) other health-care providers licensed by the Massachusetts Division of Professional Licensure, and the Board of Registration of Dietitians and Nutritionists, with specific training in the provision of nutritional counseling as provided in 42 U.S.C. 1395x(vv)(2).

405.476: Diabetes Self-management Training

(A) Introduction. MassHealth members are eligible to receive diabetes self-management training services described in 130 CMR 405.476(B). *See* Subchapter 6 of the *Community Health Center Manual* for service code descriptions and billing requirements.

(B) The MassHealth agency pays for diabetes self-management training and education, which may include medical nutrition therapy, and are furnished to an individual with pre-diabetes or diabetes. Diabetes self-management training services are payable when provided to eligible MassHealth members by the following providers:

(1) physicians;
(2) dietitians/nutritionists licensed by the Massachusetts Division of Professional Licensure, and the Board of Registration of Dietitians and Nutritionists;
(3) mid-level practitioners credentialed by the National Certification Board of Diabetes Educators (NCBDE) (e.g., nurse-midwives, nurse practitioners, registered nurses, and physician assistants); or
(4) other health-care practitioners with specific training in the provision of DSMT as provided in 42 U.S.C. 1395x(qq)(2).

(130 CMR 405.477 through 405.495 Reserved)

405.496: Utilization Management Program

The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.209 are satisfied. Appendix E of the *Community Health Center Manual* describes the information that must be provided as part of the review process.

REGULATORY AUTHORITY

130 CMR 405.000: M.G.L. c. 118E, §§ 7 and 12.

This page is reserved.

6. Service Codes and Descriptions

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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) codebook and to the HCPCS Level II codebook (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 for more information.
(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 405.424 for more information.

Note: Rates paid by MassHealth for covered codes under this Subchapter 6 for drugs, vaccines, and immune globulins administered in a provider's office are as specified in 101 CMR 317.00: *Medicine*. Subject to any other applicable provision in 101 CMR 317.00, the payment rates for these MassHealth-covered codes for drugs, vaccines and immune globulins administered in the provider's office, are equal to the fees listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (see 101 CMR 317.03(1)(c)2 and 317.04(1)(a)). For applicable codes for drugs, vaccines, and immune globulins administered in a provider's office that are listed in Section 604 below with "IC", payment set by IC will apply until such time as the code is listed and a rate set in the Quarterly ASP Medicare Part B Drug Pricing File, consistent with 101 CMR 317.04(1)(a).

602 Payable Radiology Service Codes

This section lists radiology service codes that are payable under MassHealth.

70030	70540	72120	73050	73630
70100	70542	72125	73060	73650
70110	70543	72126	73070	73660
70120	70544	72127	73080	73700
70130	70545	72128	73085	73701
70134	70546	72129	73090	73702
70140	70547	72130	73092	73718
70150	70548	72131	73100	73719
70160	70549	72132	73110	73720
70190	70551	72133	73115	73721
70200	70552	72141	73120	73722
70210	70553	72142	73130	73723
70220	70554	72146	73140	73725
70240	70555	72147	73200	74018
70250	71045	72148	73201	74019
70260	71046	72149	73202	74021
70300	71047	72156	73218	74022
70310	71048	72157	73219	74150
70320	71100	72158	73220	74160
70328	71101	72170	73221	74170
70330	71110	72190	73222	74174
70332	71111	72192	73223	74176
70336	71120	72193	73501	74177
70350	71130	72194	73502	74178
70355	71550	72195	73503	74181
70360	71551	72196	73521	74182
70370	71555	72197	73522	74183
70371	72010	72200	73523	74185
70380	72020	72202	73525	74190
70390	72040	72220	73551	74210
70450	72050	72240	73552	74220
70460	72070	72255	73560	74230
70470	72072	72265	73562	74235
70480	72074	72270	73564	74240
70481	72080	72275	73565	74245
70482	72081	72285	73580	74246
70486	72082	72295	73590	74247
70487	72083	73000	73592	74249
70488	72084	73010	73600	74250
70490	72100	73020	73610	74251
70491	72110	73030	73615	74260
70492	72114	73040	73620	74261 (PA)

602 Payable Radiology Service Codes (cont.)

74262 (PA)	75733	76499 (IC)	76873	77076
74270	75736	76506	76881	77077
74280	75741	76510	76882	77078
74283	75743	76511	76885	77080
74290	75746	76512	76886	77081
74300	75756	76513	76937	77085
74301	75774	76514	76942	77086
74330	75801	76516	76945	77293
74340	75803	76519	76946	77299 (IC)
74355	75805	76529	76948	77306
74400	75807	76536	76965	77307
74410	75809	76604	76970	77316
74415	75810	76641	76977	77317
74420	75820	76642	76978	77318
74425	75822	76700	76979	77387 (IC)
74430	75825	76705	76981	77399 (IC)
74440	75827	76706	76982	77499 (IC)
74445	75831	76770	76983	77767
74450	75833	76775	76999 (IC)	77768
74455	75840	76776	77001	77770
74470	75842	76800	77002	77771
74485	75860	76801	77003	77772
74710	75870	76802	77011	77799 (IC)
74712	75872	76805	77012	78012
74713	75880	76810	77013	78013
74740	75885	76811	77014	78014
74742	75887	76812	77021	78015
74775	75889	76813	77022	78016
75557	75891	76814	77046 (PA)	78018
75559	75893	76815	77047 (PA)	78020
75561	75898	76816	77048 (PA)	78070
75563	75901	76817	77049 (PA)	78071
75565	75902	76818	77053	78072
75572	76000	76820	77054	78075
75573	76010	76821	77061 (IC)	78099 (IC)
75574	76080	76825	77062 (IC)	78102
75600	76098	76826	77063	78103
75605	76100	76827	77065	78104
75625	76101	76828	77066	78110
75630	76102	76830	77067	78111
75705	76120	76831	77071	78120
75710	76125	76856	77072	78121
75716	76376	76857	77073	78122
75726	76377	76870	77074	78130
75731	76380	76872	77075	78135

602 Payable Radiology Service Codes (cont.)

78140	78278	78459	78607	78800
78185	78282	78466	78608	78801
78191	78290	78468	78609	78802
78195	78291	78469	78610	78803
78199 (IC)	78299 (IC)	78472	78630	78804
78201	78300	78473	78635	78805
78202	78305	78481	78645	78806
78205	78306	78483	78647	78807
78206	78315	78491	78650	78808
78215	78320	78492	78660	78811
78216	78350	78494	78699 (IC)	78812
78226	78399 (IC)	78496	78700	78813
78227	78414	78499 (IC)	78701	78814
78230	78428	78579	78707	78815
78231	78445	78580	78708	78816
78232	78451	78582	78709	78999 (IC)
78258	78452	78597	78710	79999 (IC)
78261	78453	78598	78725	
78262	78454	78599 (IC)	78730	
78264	78456	78600	78740	
78265	78457	78601	78761	
78266	78458	78605	78799 (IC)	

603 Payable Laboratory Service Codes

This section lists CPT codes and HCPCS Level II codes that are payable under MassHealth.

80047	80163	80190	80408	80438
80048	80164	80192	80410	80439
80050	80165	80194	80412	80440
80051	80168	80195	80414	81000
80053	80169	80197	80415	81001
80055	80170	80198	80416	81002
80061	80171	80199	80417	81003
80069	80173	80200	80418	81005
80074	80175	80201	80420	81007
80076	80176	80202	80422	81015
80081	80177	80203	80424	81020
80150	80178	80299	80426	81025
80155	80180	80305	80428	81050
80156	80183	80306	80430	81099 (IC)
80157	80184	80307	80432	81107 (PA)
80158	80185	80400	80434	81108 (PA)
80159	80186	80402	80435	81109 (PA)
80162	80188	80406	80436	81110 (PA)

603 Payable Laboratory Service Codes (cont.)

81111 (PA)	81253 (PA)	81361	82136	82383
81112 (PA)	81254 (PA)	81362	82139	82384
81120 (PA)	81255 (PA)	81363	82140	82387
81121 (PA)	81256 (PA)	81364	82143	82390
81161 (PA)(IC)	81257 (PA)	81400 (PA)(IC)	82150	82397
81162 (PA)	81258 (PA)	81401 (PA)(IC)	82154	82415
81163 (PA)	81260 (PA)	81403 (PA(IC)	82157	82435
81164 (PA)	81269 (PA)	81404 (PA)(IC)	82160	82436
81165 (PA)	81275 (PA)	81405 (PA)(IC)	82163	82438
81166 (PA)	81272	81407 (PA)(IC)	82164	82441
81167 (PA)	81273	81408 (PA)(IC)	82172	82465
81170	81275(PA)	81420 (PA)(IC)	82175	82480
81200	81276	81479 (PA)(IC)	82180	82482
81201	81287 (PA)	81507 (PA)(IC)	82190	82485
81202	81288 (PA)	81508 (PA)(IC)	82232	82495
81203	81292 (PA)	81509 (IC)	82239	82507
81205	81293 (PA)	81510 (IC)	82240	82523
81206	81294 (PA)	81511 (IC)	82247	82525
81207	81295 (PA)	81512 (IC)	82248	82528
81208	81296 (PA)	81519 (PA)	82252	82530
81209	81297 (PA)	82009	82261	82533
81210	81298 (PA)	82010	82270	82540
81212 (PA)	81299 (PA)	82013	82271	82542
81215 (PA)	81300 (PA)	82016	82272	82550
81216 (PA)	81301 (PA)	82017	82274	82552
81217 (PA)	81302 (PA)	82024	82286	82553
81218	81303 (PA)	82030	82300	82554
81219	81304 (PA)	82040	82306	82565
81220	81310 (PA)	82042	82308	82570
81221	81311	82043	82310	82575
81228 (PA)	81314	82044	82330	82585
81229 (PA)	81315 (PA)	82045	82331	82595
81238 (PA)	81316 (PA)	82085	82340	82600
81240 (PA)	81317 (PA)	82088	82355	82607
81241 (PA)	81318 (PA)	82103	82360	82608
81242 (PA)	81319 (PA)	82104	82365	82610
81243 (PA)	81321 (PA)	82105	82370	82615
81244 (PA)	81322 (PA)	82106	82373	82626
81245 (PA)	81323 (PA)	82107	82374	82627
81246 (PA)	81324 (PA)	82108	82375	82633
81248 (PA)	81325 (PA)	82120	82376	82634
81249 (PA)	81326 (PA)	82127	82378	82638
81250 (PA)	81330 (PA)	82128	82379	82642
81251 (PA)	81331 (PA)	82131	82380	82652
81252 (PA)	81332 (PA)	82135	82382	82656

603 Payable Laboratory Service Codes (cont.)

82657	82952	83500	83857	84133
82658	82953	83505	83861	84134
82664	82955	83516	83864	84135
82668	82960	83518	83866	84138
82670	82963	83519	83872	84140
82671	82965	83520	83873	84143
82672	82975	83525	83874	84144
82677	82977	83527	83876	84146
82679	82978	83528	83880	84150
82693	82979	83540	83883	84152
82696	82985	83550	83885	84153
82705	83001	83570	83915	84154
82710	83002	83582	83916	84155
82715	83003	83586	83918	84156
82725	83006	83593	83919	84157
82726	83008	83605	83921	84160
82728	83009	83615	83930	84163
82731	83010	83625	83935	84165
82735	83012	83630	83937	84166
82746	83013	83631	83945	84181
82747	83014	83632	83950	84182
82757	83015	83633	83951	84202
82759	83018	83655	83970	84203
82760	83020	83661	83986	84206
82775	83021	83662	83992	84207
82776	83026	83663	83993	84210
82777	83030	83664	84030	84220
82784	83033	83670	84035	84228
82785	83036	83690	84060	84233
82787	83037	83695	84066	84234
82800	83045	83698	84075	84235
82803	83050	83700	84078	84238
82805	83051	83701	84080	84244
82810	83060	83704	84081	84252
82820	83065	83718	84085	84255
82930	83068	83719	84087	84260
82938	83069	83721	84100	84270
82941	83070	83722	84105	84275
82943	83080	83727	84106	84285
82945	83088	83735	84110	84295
82946	83090	83775	84112	84300
82947	83150	83785	84119	84302
82948	83491	83789	84120	84305
82950	83497	83825	84127	84307
82951	83498	83835	84132	84311

603 Payable Laboratory Service Codes (cont.)

84315	84586	85270	85547	86161
84375	84588	85280	85549	86162
84376	84590	85290	85555	86171
84377	84591	85291	85557	86200
84378	84597	85292	85576	86215
84379	84620	85293	85597	86225
84392	84630	85300	85598	86226
84402	84681	85301	85610	86235
84403	84702	85302	85611	86243
84425	84703	85303	85612	86255
84430	84704	85305	85613	86256
84432	84999 (IC)	85306	85635	86277
84436	85002	85307	85651	86280
84437	85004	85335	85652	86294
84439	85007	85337	85660	86300
84442	85008	85345	85670	86301
84443	85009	85347	85675	86304
84445	85013	85348	85705	86308
84446	85014	85360	85730	86309
84449	85018	85362	85732	86310
84450	85025	85366	85810	86316
84460	85027	85370	85999 (IC)	86317
84466	85032	85378	86000	86318
84478	85041	85379	86001	86320
84479	85044	85380	86003	86325
84480	85045	85384	86005	86327
84481	85046	85385	86008	86329
84482	85048	85390	86021	86331
84484	85049	85396	86022	86332
84485	85055	85397	86023	86334
84488	85060	85400	86038	86335
84490	85097	85410	86039	86336
84510	85130	85415	86060	86337
84512	85170	85420	86063	86340
84520	85175	85421	86140	86341
84525	85210	85441	86141	86343
84540	85220	85445	86146	86344
84545	85230	85460	86147	86352
84550	85240	85461	86148	86353
84560	85244	85475	86152	86355
84577	85245	85520	86153	86356
84578	85246	85525	86155	86357
84580	85247	85530	86156	86359
84583	85250	85536	86157	86360
84585	85260	85540	86160	86361

603 Payable Laboratory Service Codes (cont.)

86367	86664	86762	86902	87149
86376	86665	86765	86904	87152
86382	86666	86768	86905	87158
86384	86668	86771	86906	87164
86386	86671	86774	86920	87166
86403	86674	86777	86921	87168
86406	86677	86778	86922	87169
86430	86682	86780	86923	87172
86431	86684	86784	86940	87176
86480	86687	86787	86941	87177
86481	86688	86788	86970	87181
86485	86689	86789	86971	87184
86486	86692	86790	86972	87185
86490	86694	86793	86975	87186
86510	86695	86800	86976	87187
86590	86696	86803	86977	87188
86592	86698	86804	86978	87190
86593	86701	86805	86999 (IC)	87197
86602	86702	86806	87003	87205
86603	86703	86807	87015	87206
86606	86704	86808	87040	87207
86609	86705	86812	87045	87209
86611	86706	86813	87046	87210
86612	86707	86816	87070	87220
86615	86708	86817	87071	87230
86617	86709	86821	87073	87250
86618	86710	86825	87075	87252
86619	86711	86826	87076	87253
86622	86713	86828	87077	87254
86625	86717	86829	87081	87255
86628	86720	86830	87084	87260
86631	86723	86831	87086	87265
86632	86727	86832	87088	87267
86635	86732	86833	87101	87269
86638	86734	86834	87102	87270
86641	86735	86835	87103	87271
86644	86738	86849 (IC)	87106	87272
86645	86741	86850	87107	87273
86648	86744	86860	87109	87274
86651	86747	86870	87110	87275
86652	86750	86880	87116	87276
86653	86753	86885	87118	87278
86654	86756	86886	87140	87279
86658	86757	86900	87143	87280
86663	86759	86901	87147	87281

603 Payable Laboratory Service Codes (cont.)

87283	87490	87557	87903	88235
87285	87491	87560	87904	88237
87290	87492	87561	87905	88239
87299	87495	87562	87906	88240
87300	87496	87580	87910	88241
87301	87497	87581	87912	88245
87305	87498	87582	87999 (PA)(IC)	88248
87320	87500	87590	88104	88249
87324	87501	87591	88106	88261
87327	87502	87592	88108	88262
87328	87503	87623	88112	88263
87329	87505	87624	88120	88264
87332	87506	87625	88121	88267
87335	87507	87631	88130	88269
87336	87510	87632	88140	88271
87337	87511	87633	88141	88272
87338	87512	87634	88142	88273
87339	87516	87640	88143	88274
87340	87517	87641	88147	88275
87341	87520	87650	88148	88280
87350	87521	87651	88150	88283
87380	87522	87652	88152	88285
87385	87525	87653	88153	88289
87389	87526	87660	88155	88291
87390	87527	87661	88160	88299 (IC)
87391	87528	87662	88161	88300
87400	87529	87797	88162	88302
87420	87530	87798	88164	88304
87425	87531	87799	88165	88305
87427	87532	87800	88166	88307
87430	87533	87801	86167	88309
87449	87534	87802	88172	88311
87450	87535	87803	88173	88312
87451	87536	87804	88174	88313
87471	87537	87806	88175	88314
87472	87538	87807	88177	88319
87475	87539	87808	88182	88341
87476	87540	87809	88184	88342
87480	87541	87810	88185	88344
87481	87542	87850	88187	88346
87482	87550	87880	88188	88348
87483	87551	87899	88189	88350
87485	87552	87900	88199 (IC)	88355
87486	87555	87901	88230	88356
87487	87556	87902	88233	88358

603 Payable Laboratory Service Codes (cont.)

88360	88381	89125	93015	93228
88361	88387	89160	93016	93229 (IC)
88362	88388	89190	93017	93268
88363	88399 (IC)	89220 (IC)	93018	93278
88364	88720	89230 (IC)	93024	93724
88365	88740	89240 (IC)	93040	93799 (IC)
88367	88741	89300	93041	G0027
88368	89049	89310	93042	G0480
88369	89050	89320	93224	G0481
88371	89051	93000	93225	G0482
88372	89055	93005	93226	G0483
88380 (IC)	89060	93010	93227	P9604

604 Payable Visit and Vaccine Service Codes

This section lists visit and vaccine service codes that are payable under MassHealth.

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.) The cost of the administration of the vaccine is included in the CHC visit rate and is not separately payable.

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

Service Code	Modifier	Special Requirement or Limitation
A4261		Cervical cap for contraceptive use (I.C.)
A4266		Diaphragm for contraceptive use (includes applicator and cream or jelly)
A4267		Contraceptive supply, condom, male, each
A4268		Contraceptive supply, condom, female, each
A4269		Contraceptive supply, spermicide (e.g., foam, gel), each (per package/tube)
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.
J1050		Injection, medroxyprogesterone acetate, 1 mg (I.C.)
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)
J3490	FP	Use for medications and injectables related to family planning services, with the exception of (a) Rho(D) human immune globulin; and (b) contraceptive injectables such as Depo-Provera, items for which MassHealth will pay the provider's cost.) (I.C.)
J7296		Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Modifier	Special Requirement or Limitation
J7297		Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration (I.C.)
J7298		Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (I.C.)
J7300		Intrauterine copper contraceptive (use for Paragard) (I.C.)
J7301		Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg (I.C.)
J7303		Contraceptive supply, hormone-containing vaginal ring, each (I.C.)
J7304		Contraceptive supply, hormone-containing patch, each (I.C.)
J7307		tonogestrel (contraceptive) implant system, including implant and supplies (must be billed with either 11981 or 11983) (I.C.)
S4989		Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (I.C.)
S4993		Contraceptive pills for birth control
G0469		Use for individual mental health visit, new patient (This code can be billed via telehealth)
G0470		Use for individual mental health visit, established patient (This code can be billed via telehealth)
T1015		Use for individual medical visit.
T1015	HQ	Use for group clinic visit.
90791		Use for psychiatric diagnostic evaluation. (This code can be billed via telehealth)
90832		Use for psychotherapy, 30 minutes with patient and/or family member. (This code can be billed via telehealth)
90834		Use for psychotherapy, 45 minutes with patient and/or family member. (This code can be billed via telehealth)
90836		Use for psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management services (list separately in addition to the code for primary procedure). (This code can be billed via telehealth)
90837		Use for psychotherapy, 60 minutes with patient and/or family. (This code can be billed via telehealth)
90853		Use for group psychotherapy (other than of a multiple-family group) (per person not to exceed 10 clients). (This code can be billed via telehealth)
90882		Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions. (This code can be billed via telehealth)
96130		Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Modifier	Special Requirement or Limitation
96132		Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
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.
99188		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.
99402		Use for HIV counseling visits.

(B) This section lists evaluation and management visit service codes that are payable under MassHealth.

99218	99226	99306	99327	99345 (IC)
99219	99231	99307	99334	99347
99220	99232	99308	99335	99348
99221	99233	99309	99336	99349
99222	99238	99310	99337	99350 (IC)
99223	99239	99324	99341	99460
99224	99304	99325	99342	99462
99225	99305	99326	99343	

(C) This section lists evaluation and management visit service codes that are payable under MassHealth. 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	90473
90461	90474
90471	
90472	

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Special Requirement or Limitation

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

Service Code	Special Requirement or Limitation
90476	Adenovirus vaccine, type 4, live, for oral use (IC)
90477	Adenovirus vaccine, type 7, live, for oral use (IC)
90581	Anthrax vaccine, for subcutaneous or intramuscular use (IC)
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use. (IC)
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 3 dose schedule, for intramuscular use. (IC)
90625	Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use. (IC)
90630	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90632	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90633	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90636	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90651	Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children younger than19 years of age. (IC)
90654	Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90656	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.
90658	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90660	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90661	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90662	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90664	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90666	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90667	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90668	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Special Requirement or Limitation
90670	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90672	Covered for members aged 19 to 49; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90673	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90676	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90682	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90686	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90688	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90690	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90696	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90707	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90710	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90713	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)
90714	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90715	Covered for members > 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90716	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than19 years of age. (IC)
90732	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than19 years of age.
90733	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90734	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)
90736	PA is required for members < age 50. (IC)
90738	Japanese encephalitis virus vaccine, inactivated, for intramuscular use (IC)
90739	Covered for members >19 (IC)
90746	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.
90749	Unlisted vaccine/toxoid (IC)
90750	PA is required for members < age 50. (IC)

604 Payable Visit and Vaccine Service Codes (cont.)

Service Code	Special Requirement or Limitation
90756	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.

605 Payable Obstetrics Service Codes

This section lists obstetrics service codes that are payable under MassHealth.

See 130 CMR 405.422 through 405.426 for other requirements.

Fee-for-Service Deliveries

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

Global Deliveries

59400	59610
59510	59618

606 Payable Surgery Service Codes

This section lists surgery service codes that are payable under MassHealth.

11976 (S.P.)	56440
11981	56501
11982	56515
11983	56605
19100	57061
44955	57100
49082	57240
49083	57250
49084	57260
49255	57420
49320	57421
54050	57425
54057	57452
54150	57454
54160	57455
55250 (CS-18 or CS-21 required) (SP)	57456
56420	57460

606 Payable Surgery Service Codes (cont.)

57461
57500
57505
57510
57511
57513
57520
57522
57700
57800 (S.P.)
58100 (S.P.)
58120
58140
58146
58150 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)
58180 (HI-1 form required; PA or Gender Dysphoria-Related Services Only)
58300
58301
58340
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 (S.P.)
58558
58560
58561
58562
58565 (CS-18 or CS-21 required)
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.

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.

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 health assessment service codes that are payable under MassHealth. The cost of the administration of the vaccine is included in the EPSDT visit rate and is not separately payable.

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 audiometric hearing and vision test service codes that are payable under MassHealth.

92551	92552	92587	99173

611 Payable Tobacco-Cessation Service Codes

This section lists tobacco-cessation service codes that are payable under MassHealth.

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.

611 Payable Tobacco-Cessation Service Codes

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.

G0108	Diabetes outpatient self-management training services, individual, per 30 minutes.
G0109	Diabetes outpatient self-management training services, group session (2 or more, per 30 minutes.
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours, needed for renal disease), individual, face-to-face with patient, each 15 minutes.
G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours, needed for renal disease), group (2 or more individuals), each 30 minutes.
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes

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613 Payable Behavioral Health Screening Tool Service Codes

This section lists behavioral health screening tool service codes that are payable under MassHealth.

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 96110** must be accompanied by one of the modifiers listed below to indicate whether a behavioral health need was identified.*

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

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.)
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.)

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

Service Code	Modifier	Special Requirement or Limitation
96110	UD	Covered for members birth to 6 months for the administration and scoring of the Edinburgh Postnatal Depression Scale. UD must be used together with one of the above modifiers, U1–U8.

** "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 Postpartum Depression Screening Tools

Service Code S3005 is used for the performance measurement and evaluation of patient self-assessment and depression. **Code S3005** must be accompanied by one of the modifiers below to indicate whether a behavioral health need was identified.

Modifier	Description
U1	Perinatal Care Provider – Positive Screen: completed prenatal or postpartum depression screening and behavioral health need identified.
U2	Perinatal Care Provider – Negative Screen: completed prenatal or postpartum depression screening with no behavioral health need identified.

Please refer to the Massachusetts Department of Public Health's (DPH) postpartum depression (PPD) screening tool grid for any revisions to the list of MassHealth-approved screening tools: www.mass.gov/service-details/postpartum-depression-resources-for-healthcare-providers

615 Payable Acupuncture Service Codes

This section lists acupuncture service codes that are payable under MassHealth.
97810
97811
97813
97814

616 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 a 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
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)
QW	CLIA waived test
RT	Right side (used to identify procedures performed on the right side of the body)
TC	Technical Component
XE	Separate Encounter: a service that is distinct because it occurred during a separate encounter
XP	Separate Practitioner: a service that is distinct because it was performed by a different practitioner
XS	Separate Structure: a service that is distinct because it was performed on a separate organ/structure
XU	Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service

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.