|  |  |
| --- | --- |
|  | ***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 [Signature of Daniel Tsai]

**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

A4266

A4267

A4268

A4269

G0469

G0470

J1050

J3490 FP

J7296

J7297

J7298

J7300

J7301

J7303

J7304

J7307

S4989

S4993

11976

11981

11982

11983

19100

49082

49083

49084

54050

56501

56515

56605

57061

57100

57420

57421

57425

57452

57454

57455

57456

57460

57461

57500

57505

57510

57511

57513

57800

58100

58300

58301

58340

58562

58565

76978

76979

76981

76982

76983

77046

77047

77048

77049

81163

81164

81165

81166

82642

83722

96130

96132

# Deleted Codes

76001

77058

77059

78270

78271

78272

90792

99213

## Telehealth Services

Effective January 1, 2019, in accordance with All Provider Bulletin 281 (available at [www.mass.gov/lists/all-provider-bulletins](http://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

G0470

90791

90832

90834

90836

90837

90853

90882

# 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](https://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](http://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](mailto: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](mailto: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

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  Table of Contents | **Page**  iv |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

4. Program Regulations

405.401: Introduction 4‑1

405.402: Definitions 4‑1

405.403: Eligible Members 4‑3

405.404: Provider Eligibility 4-4

405.405: Certification 4‑4

405.406: Administrative Requirements 4‑5

405.407: Physician Time Required on Site 4‑6

405.408: Medical Services Required on Site 4‑6

405.409: Medical Services Required on Site or by Referral 4‑8

(130 CCMR 405.410 Reserved)

405.411: Continuity of Care 4‑10

405.412: Record-keeping Requirements 4‑10

405.413: Coordination of Services 4‑11

405.414: Translation Services 4-11

405.415: Emergency Backup Services 4‑11

405.416: Quality Assessment Program 4‑12

405.417: Maximum Allowable Fees 4‑12

405.418: Nonreimbursable Services 4‑12

(130 CMR 405.419 and 405.420 Reserved)

405.421: Visits: Service Limitations 4‑13

405.422: Obstetric Services: Introduction 4‑14

405.423: Obstetric Services: Global-fee Method of Payment 4‑15

405.424: Hysterectomy Services 4-16

(130 CMR 405.425 Reserved)

405.426: Obstetric Services: Fee-for-service Method of Payment 4‑18

405.427: Certified Nurse‑midwife Services 4‑18

405.428: Sterilization Services: Introduction 4-19

405.429: Sterilization Services: Informed Consent 4-19

405.430: Sterilization Services: Consent Form Requirements 4-20

405.431: Laboratory Services: Introduction 4‑22

405.432: Laboratory Services: Eligibility to Provide Services 4‑22

405.433: Laboratory Services: Service Limitations 4‑22

405.434: Laboratory Services: Services Performed by Outside Laboratories 4‑23

(130 CMR 405.435 through 405.440 Reserved)

405.441: Radiology Services: Introduction 4‑24

405.442: Radiology Services: Service Limitations 4‑24

405.443: Radiology Services: Payment Limitations 4‑25

(130 CMR 405.444 through 405.450 Reserved)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  Table of Contents | **Page**  iv-a |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

4. Program Regulations (cont.)

405.451: Electrocardiogram (EKG) Services: Introduction 4-26

405.452: Electrocardiogram (EKG) Services: Eligibility to Provide Services 4-26

405.453: Electrocardiogram (EKG) Services: Payment Limitations 4-26

(130 CMR 405.454 through 405.460 Reserved)

405.461: Audiology Services: Introduction 4-27

405.462: Audiology Services: Eligibility to Provide Services 4.27

405.463: Audiology Services: Payment Limitations 4-27

(130 CMR 405.464 and 405.465 Reserved)

405.466: Pharmacy Services: Participation in the 340B Drug-Pricing Program for

Outpatient CHC Pharmacies 4-28

405.467: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services 4-28

405.468: Drugs Administered in the CHC (Provider-administered Drugs) 4-28

(130 CMR 405.469 through 405.470 Reserved)

405.471: Optional Reimbursable Services 4-30

405.472: Tobacco-cessation Services 4-30

405.473: Fluoride Varnish Services 4-32

405.474: Acupuncture Services 4-32

405.475: Medical Nutrition Therapy 4-33

405.476: Diabetes Self-management Training 4-34

(130 CMR 405.477 through 405.495 Reserved)

405.496: Utilization Management Program 4-35

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-1 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-2 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-3 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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*.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-4 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-5 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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).

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-6 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-7 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-8 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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;

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-9 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(L) radiology services;

(M) speech/language therapy services; and

(N) vision care services.

(130 CMR 405.410 Reserved)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-10 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-11 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-12 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-13 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-14 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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).

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-15 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-16 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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).

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-17 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-18 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-19 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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;

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-20 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-21 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-22 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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).

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-23 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-24 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-25 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-26 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-27 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-28 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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*.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-29 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-30 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-31 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-32 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-33 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

(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).

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-34 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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)

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-35 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

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.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  4. Program Regulations  (130 CMR 405.000) | **Page**  4-36 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  03/22/19 |

This page is reserved.

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  6. Service Codes and Descriptions | **Page**  vi |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  01/01/19 |

6. Service Codes and Descriptions

Introduction and Explanation of Abbreviations 6-1

Payable Radiology Service Codes 6-2

Payable Laboratory Service Codes 6-4

Payable Visit and Vaccine Service Codes 6-10

Payable Obstetrics Service Codes 6-15

Payable Surgery Service Codes 6-15

Payable Nurse-midwife Service Codes 6-16

Payable Audiology Service Codes 6-17

Payable Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

Health Assessment Service Codes 6-17

Payable Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

Audiometric Hearing and Vision Test Service Codes 6-17

Payable Tobacco-cessation Service Codes 6-17

Payable Medical Nutrition Therapy and Diabetes Self-Management Training Service Codes 6-18

Payable Behavioral Health Screening Tool Service Codes 6-19

Payable Postpartum Depression Screening Tools 6-20

Payable Acupuncture Service Codes 6-20

Modifiers 6-21

Appendix A. Directory A-1

Appendix C. Third-Party-Liability Codes C-1

Appendix D. Supplemental Instructions for TPL Exceptions D-1

Appendix E. Utilization Management Program E-1

Appendix F. Admission Guidelines F-1

Appendix T. CMSP Covered Codes T-1

Appendix U. DPH-Designated Serious Reportable Events That Are Not Provider

Preventable Conditions U-1

Appendix V. MassHealth Billing Instructions for Provider Preventable Conditions V-1

Appendix W. EPSDT Services Medical and Dental Protocols and Periodicity Schedules W-1

Appendix X. Family Assistance Copayments and Deductibles X-1

Appendix Y. EVS Codes/Messages Y-1

Appendix Z. EPSDT/PPHSD Screening Services Codes Z-1

|  |  |  |
| --- | --- | --- |
| **Commonwealth of Massachusetts**  **MassHealth**  **Provider Manual Series** | **Subchapter Number and Title**  6. Service Codes and Descriptions | **Page**  6-1 |
| Community Health Center Manual | **Transmittal Letter**  CHC-112 | **Date**  01/01/19 |

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](http://www.cms.gov)).

The following abbreviations are used in Subchapter 6.

1. PA indicates that service-specific prior authorization is required. See 130 CMR 450.303 for more information.
2. IC indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim. See 130 CMR 450.271.
3. 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.
4. 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.
5. 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.
6. 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

70100

70110

70120

70130

70134

70140

70150

70160

70190

70200

70210

70220

70240

70250

70260

70300

70310

70320

70328

70330

70332

70336

70350

70355

70360

70370

70371

70380

70390

70450

70460

70470

70480

70481

70482

70486

70487

70488

70490

70491

70492

70540

70542

70543

70544

70545

70546

70547

70548

70549

70551

70552

70553

70554

70555

71045

71046

71047

71048

71100

71101

71110

71111

71120

71130

71550

71551

71555

72010

72020

72040

72050

72070

72072

72074

72080

72081

72082

72083

72084

72100

72110

72114

72120

72125

72126

72127

72128

72129

72130

72131

72132

72133

72141

72142

72146

72147

72148

72149

72156

72157

72158

72170

72190

72192

72193

72194

72195

72196

72197

72200

72202

72220

72240

72255

72265

72270

72275

72285

72295

73000

73010

73020

73030

73040

73050

73060

73070

73080

73085

73090

73092

73100

73110

73115

73120

73130

73140

73200

73201

73202

73218

73219

73220

73221

73222

73223

73501

73502

73503

73521

73522

73523

73525

73551

73552

73560

73562

73564

73565

73580

73590

73592

73600

73610

73615

73620

73630

73650

73660

73700

73701

73702

73718

73719

73720

73721

73722

73723

73725

74018

74019

74021

74022

74150

74160

74170

74174

74176

74177

74178

74181

74182

74183

74185

74190

74210

74220

74230

74235

74240

74245

74246

74247

74249

74250

74251

74260

74261 (PA)

74262 (PA)

74270

74280

74283

74290

74300

74301

74330

74340

74355

74400

74410

74415

74420

74425

74430

74440

74445

74450

74455

74470

74485

74710

74712

74713

74740

74742

74775

75557

75559

75561

75563

75565

75572

75573

75574

75600

75605

75625

75630

75705

75710

75716

75726

75731

75733

75736

75741

75743

75746

75756

75774

75801

75803

75805

75807

75809

75810

75820

75822

75825

75827

75831

75833

75840

75842

75860

75870

75872

75880

75885

75887

75889

75891

75893

75898

75901

75902

76000

76010

76080

76098

76100

76101

76102

76120

76125

76376

76377

76380

76499 (IC)

76506

76510

76511

76512

76513

76514

76516

76519

76529

76536

76604

76641

76642

76700

76705

76706

76770

76775

76776

76800

76801

76802

76805

76810

76811

76812

76813

76814

76815

76816

76817

76818

76820

76821

76825

76826

76827

76828

76830

76831

76856

76857

76870

76872

76873

76881

76882

76885

76886

76937

76942

76945

76946

76948

76965

76970

76977

76978

76979

76981

76982

76983

76999 (IC)

77001

77002

77003

77011

77012

77013

77014

77021

77022

77046 (PA)

77047 (PA)

77048 (PA)

77049 (PA)

77053

77054

77061 (IC)

77062 (IC)

77063

77065

77066

77067

77071

77072

77073

77074

77075

77076

77077

77078

77080

77081

77085

77086

77293

77299 (IC)

77306

77307

77316

77317

77318

77387 (IC)

77399 (IC)

77499 (IC)

77767

77768

77770

77771

77772

77799 (IC)

78012

78013

78014

78015

78016

78018

78020

78070

78071

78072

78075

78099 (IC)

78102

78103

78104

78110

78111

78120

78121

78122

78130

78135

78140

78185

78191

78195

78199 (IC)

78201

78202

78205

78206

78215

78216

78226

78227

78230

78231

78232

78258

78261

78262

78264

78265

78266

78278

78282

78290

78291

78299 (IC)

78300

78305

78306

78315

78320

78350

78399 (IC)

78414

78428

78445

78451

78452

78453

78454

78456

78457

78458

78459

78466

78468

78469

78472

78473

78481

78483

78491

78492

78494

78496

78499 (IC)

78579

78580

78582

78597

78598

78599 (IC)

78600

78601

78605

78607

78608

78609

78610

78630

78635

78645

78647

78650

78660

78699 (IC)

78700

78701

78707

78708

78709

78710

78725

78730

78740

78761

78799 (IC)

78800

78801

78802

78803

78804

78805

78806

78807

78808

78811

78812

78813

78814

78815

78816

78999 (IC)

79999 (IC)

603 Payable Laboratory Service Codes

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

80047

80048

80050

80051

80053

80055

80061

80069

80074

80076

80081

80150

80155

80156

80157

80158

80159

80162

80163

80164

80165

80168

80169

80170

80171

80173

80175

80176

80177

80178

80180

80183

80184

80185

80186

80188

80190

80192

80194

80195

80197

80198

80199

80200

80201

80202

80203

80299

80305

80306

80307

80400

80402

80406

80408

80410

80412

80414

80415

80416

80417

80418

80420

80422

80424

80426

80428

80430

80432

80434

80435

80436

80438

80439

80440

81000

81001

81002

81003

81005

81007

81015

81020

81025

81050

81099 (IC)

81107 (PA)

81108 (PA)

81109 (PA)

81110 (PA)

81111 (PA)

81112 (PA)

81120 (PA)

81121 (PA)

81161 (PA)(IC) 81162 (PA)

81163 (PA)

81164 (PA)

81165 (PA)

81166 (PA)

81167 (PA)

81170

81200

81201

81202

81203

81205

81206

81207

81208

81209

81210

81212 (PA)

81215 (PA)

81216 (PA)

81217 (PA)

81218

81219

81220

81221

81228 (PA)

81229 (PA)

81238 (PA)

81240 (PA)

81241 (PA)

81242 (PA)

81243 (PA)

81244 (PA)

81245 (PA)

81246 (PA)

81248 (PA)

81249 (PA)

81250 (PA)

81251 (PA)

81252 (PA)

81253 (PA)

81254 (PA)

81255 (PA)

81256 (PA)

81257 (PA)

81258 (PA)

81260 (PA)

81269 (PA)

81275 (PA)

81272

81273

81275(PA)

81276

81287 (PA)

81288 (PA)

81292 (PA)

81293 (PA)

81294 (PA)

81295 (PA)

81296 (PA)

81297 (PA)

81298 (PA)

81299 (PA)

81300 (PA)

81301 (PA)

81302 (PA)

81303 (PA)

81304 (PA)

81310 (PA)

81311

81314

81315 (PA)

81316 (PA)

81317 (PA)

81318 (PA)

81319 (PA)

81321 (PA)

81322 (PA)

81323 (PA)

81324 (PA)

81325 (PA)

81326 (PA)

81330 (PA)

81331 (PA)

81332 (PA)

81361

81362

81363

81364

81400 (PA)(IC)

81401 (PA)(IC)

81403 (PA(IC)

81404 (PA)(IC)

81405 (PA)(IC)

81407 (PA)(IC)

81408 (PA)(IC)

81420 (PA)(IC)

81479 (PA)(IC)

81507 (PA)(IC)

81508 (PA)(IC)

81509 (IC)

81510 (IC)

81511 (IC)

81512 (IC)

81519 (PA)

82009

82010

82013

82016

82017

82024

82030

82040

82042

82043

82044

82045

82085

82088

82103

82104

82105

82106

82107

82108

82120

82127

82128

82131

82135

82136

82139

82140

82143

82150

82154

82157

82160

82163

82164

82172

82175

82180

82190

82232

82239

82240

82247

82248

82252

82261

82270

82271

82272

82274

82286

82300

82306

82308

82310

82330

82331

82340

82355

82360

82365

82370

82373

82374

82375

82376

82378

82379

82380

82382

82383

82384

82387

82390

82397

82415

82435

82436

82438

82441

82465

82480

82482

82485

82495

82507

82523

82525

82528

82530

82533

82540

82542

82550

82552

82553

82554

82565

82570

82575

82585

82595

82600

82607

82608

82610

82615

82626

82627

82633

82634

82638

82642

82652

82656

82657

82658

82664

82668

82670

82671

82672

82677

82679

82693

82696

82705

82710

82715

82725

82726

82728

82731

82735

82746

82747

82757

82759

82760

82775

82776

82777

82784

82785

82787

82800

82803

82805

82810

82820

82930

82938

82941

82943

82945

82946

82947

82948

82950

82951

82952

82953

82955

82960

82963

82965

82975

82977

82978

82979

82985

83001

83002

83003

83006

83008

83009

83010

83012

83013

83014

83015

83018

83020

83021

83026

83030

83033

83036

83037

83045

83050

83051

83060

83065

83068

83069

83070

83080

83088

83090

83150

83491

83497

83498

83500

83505

83516

83518

83519

83520

83525

83527

83528

83540

83550

83570

83582

83586

83593

83605

83615

83625

83630

83631

83632

83633

83655

83661

83662

83663

83664

83670

83690

83695

83698

83700

83701

83704

83718

83719

83721

83722

83727

83735

83775

83785

83789

83825

83835

83857

83861

83864

83866

83872

83873

83874

83876

83880

83883

83885

83915

83916

83918

83919

83921

83930

83935

83937

83945

83950

83951

83970

83986

83992

83993

84030

84035

84060

84066

84075

84078

84080

84081

84085

84087

84100

84105

84106

84110

84112

84119

84120

84127

84132

84133

84134

84135

84138

84140

84143

84144

84146

84150

84152

84153

84154

### 84155

84156

84157

### 84160

### 84163

### 84165

84166

84181

84182

84202

84203

84206

84207

84210

84220

84228

84233

84234

84235

84238

84244

84252

84255

84260

84270

84275

84285

84295

84300

84302

84305

84307

84311

84315

84375

84376

84377

84378

84379

84392

84402

84403

84425

84430

84432

84436

84437

84439

84442

84443

84445

84446

84449

84450

84460

84466

84478

84479

84480

84481

84482

84484

84485

84488

84490

84510

84512

84520

84525

84540

84545

84550

84560

84577

84578

84580

84583

84585

84586

84588

84590

84591

84597

84620

84630

84681

84702

84703

84704

84999 (IC)

85002

85004

85007

85008

85009

85013

85014

85018

85025

85027

85032

85041

85044

85045

85046

85048

85049

85055

85060

85097

85130

85170

85175

85210

85220

85230

85240

85244

85245

85246

85247

85250

85260

85270

85280

85290

85291

85292

85293

85300

85301

85302

85303

85305

85306

85307

85335

85337

85345

85347

85348

85360

85362

85366

85370

85378

85379

85380

85384

85385

85390

85396

85397

85400

85410

85415

85420

85421

85441

85445

85460

85461

85475

85520

85525

85530

85536

85540

85547

85549

85555

85557

85576

85597

85598

85610

85611

85612

85613

85635

85651

85652

85660

85670

85675

85705

85730

85732

85810

85999 (IC)

86000

86001

86003

86005

86008

86021

86022

86023

86038

86039

86060

86063

86140

86141

86146

86147

86148

86152

86153

86155

86156

86157

86160

86161

86162

86171

86200

86215

86225

86226

86235

86243

86255

86256

86277

86280

86294

86300

86301

86304

86308

86309

86310

86316

86317

86318

86320

86325

86327

86329

86331

86332

86334

86335

86336

86337

86340

86341

86343

86344

86352

86353

86355

86356

86357

86359

86360

86361

86367

86376

86382

86384

86386

86403

86406

86430

86431

86480

86481

86485

86486

86490

86510

86590

86592

86593

86602

86603

86606

86609

86611

86612

86615

86617

86618

86619

86622

86625

86628

86631

86632

86635

86638

86641

86644

86645

86648

86651

86652

86653

86654

86658

86663

86664

86665

86666

86668

86671

86674

86677

86682

86684

86687

86688

86689

86692

86694

86695

86696

86698

86701

86702

86703

86704

86705

86706

86707

86708

86709

86710

86711

86713

86717

86720

86723

86727

86732

86734

86735

86738

86741

86744

86747

86750

86753

86756

86757

86759

86762

86765

86768

86771

86774

86777

86778

86780

86784

86787

86788

86789

86790

86793

86800

86803

86804

86805

86806

86807

86808

86812

86813

86816

86817

86821

86825

86826

86828

86829

86830

86831

86832

86833

86834

86835

86849 (IC)

86850

86860

86870

86880

86885

86886

86900

86901

86902

86904

86905

86906

86920

86921

86922

86923

86940

86941

86970

86971

86972

86975

86976

86977

86978

86999 (IC)

87003

87015

87040

87045

87046

87070

87071

87073

87075

87076

87077

87081

87084

87086

87088

87101

87102

87103

87106

87107

87109

87110

87116

87118

87140

87143

87147

87149

87152

87158

87164

87166

87168

87169

87172

87176

87177

87181

87184

87185

87186

87187

87188

87190

87197

87205

87206

87207

87209

87210

87220

87230

87250

87252

87253

87254

87255

87260

87265

87267

87269

87270

87271

87272

87273

87274

87275

87276

87278

87279

87280

87281

87283

87285

87290

87299

87300

87301

87305

87320

87324

87327

87328

87329

87332

87335

87336

87337

87338

87339

87340

87341

87350

87380

87385

87389

87390

87391

87400

87420

87425

87427

87430

87449

87450

87451

87471

87472

87475

87476

87480

87481

87482

87483

87485

87486

87487

87490

87491

87492

87495

87496

87497

87498

87500

87501

87502

87503

87505

87506

87507

87510

87511

87512

87516

87517

87520

87521

87522

87525

87526

87527

87528

87529

87530

87531

87532

87533

87534

87535

87536

87537

87538

87539

87540

87541

87542

87550

87551

87552

87555

87556

87557

87560

87561

87562

87580

87581

87582

87590

87591

87592

87623

87624

87625

87631

87632

87633

87634

87640

87641

87650

87651

87652

87653

87660

87661

87662

87797

87798

87799

87800

87801

87802

87803

87804

87806

87807

87808

87809

87810

87850

87880

87899

87900

87901

87902

87903

87904

87905

87906

87910

87912

87999 (PA)(IC)

88104

88106

88108

88112

88120

88121

88130

88140

88141

88142

88143

88147

88148

88150

88152

88153

88155

88160

88161

88162

88164

88165

88166

86167

88172

88173

88174

88175

88177

88182

88184

88185

88187

88188

88189

88199 (IC)

88230

88233

88235

88237

88239

88240

88241

88245

88248

88249

88261

88262

88263

88264

88267

88269

88271

88272

88273

88274

88275

88280

88283

88285

88289

88291

88299 (IC)

88300

88302

88304

88305

88307

88309

88311

88312

88313

88314

88319

88341

88342

88344

88346

88348

88350

88355

88356

88358

88360

88361

88362

88363

88364

88365

88367

88368

88369

88371

88372

88380 (IC)

88381

88387

88388

88399 (IC)

88720

88740

88741

89049

89050

89051

89055

89060

89125

89160

89190

89220 (IC)

89230 (IC)

89240 (IC)

89300

89310

89320

93000

93005

93010

93015

93016

93017

93018

93024

93040

93041

93042

93224

93225

93226

93227

93228

93229 (IC)

93268

93278

93724

93799 (IC)

G0027

G0480

G0481

G0482

G0483

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

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

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

99219

99220

99221

99222

99223

99224

99225

99226

99231

99232

99233

99238

99239

99304

99305

99306

99307

99308

99309

99310

99324

99325

99326

99327

99334

99335

99336

99337

99341

99342

99343

99345 (IC)

99347

99348

99349

99350 (IC)

99460

99462

(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

90461

90471

90472

90473

90474

(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)

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)

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

59410

59414

59514

59515

59525 (HI-1 form required)

59612

59614

59620

59622

Global Deliveries

59400

59510

59610

59618

606 Payable Surgery Service Codes

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

11976 (S.P.)

11981

11982

11983

19100

44955

49082

49083

49084

49255

49320

54050

54057

54150

54160

55250 (CS-18 or CS-21 required) (SP)

56420

56440

56501

56515

56605

57061

57100

57240

57250

57260

57420

57421

57425

57452

57454

57455

57456

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

99382

99383

99384

99385

99391

99392

99393

99394

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.

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

.

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](http://www.mass.gov/eohhs/docs/masshealth/providermanual/appx-w-all.pdf) 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.\*

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.)

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](http://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.

This publication contains codes that are copyrighted by the American Medical Association. Certain terms used in the service descriptions for HCPCS codes are defined in the *Current Procedural Terminology (CPT) Professional* codebook.