TO: Community Health Centers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth


Summary
This letter transmits updates to Subchapter 6 of the Community Health Center Manual regarding new requirements for prior authorization (PA) for the provision of advanced imaging services, non-obstetric ultrasounds, polysomnography, and cardiology services. This PA requirement applies to outpatient services only and does not apply to services rendered in an emergency department or an inpatient setting.

This change will impact only those members enrolled in MassHealth fee-for-service, a Primary Care ACO plan, or the Primary Care Clinician (PCC) plan. Providers serving members enrolled in a MassHealth-contracted accountable care partnership plan (ACPP), managed care organization (MCO), integrated care organization (ICO), senior care organization (SCO), or Program of All-inclusive Care for the Elderly (PACE) should refer to the ACPP’s, MCO’s, ICO’s, SCO’s, or PACE’s medical policies for covered services.

New MassHealth Third-Party Administrator for Prior Authorization
As part of MassHealth’s efforts to provide its members with access to high quality, cost-effective care, MassHealth has contracted with eviCore healthcare (eviCore) to provide utilization management programs for advanced imaging services, non-obstetric ultrasounds, polysomnography, and cardiology services. Among other things, eviCore will evaluate all requests for PA for the services identified in this letter.

In the coming weeks, eviCore will be leading training sessions designed to assist provider organizations in fulfilling the new utilization management program requirements, such as the new PA requirements communicated by this letter. eviCore will offer these online training sessions on a variety of dates and times to accommodate provider availability and to encourage participation.

During these sessions, eviCore will provide a detailed overview of the new PA requirements, along with instructions for navigating the eviCore website at www.evicore.com. Providers will also have the opportunity to ask questions and seek additional clarification where needed.
The training session offerings for each program are outlined in the following table.

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**How to Register**

Please read the following instructions to register for and participate in a session:
1. Once you have selected a session, please go to [http://eviCore.webex.com/](http://eviCore.webex.com/)
2. Click on the menu bar on the upper left hand side—the three horizontal lines underneath the eviCore healthcare logo. Then choose “Webex Training”
3. Under Live Sessions, click the “Upcoming” tab, then enter the desired topic name exactly as listed in the table and search
4. Click “Register” next to the session(s) with the date and time you wish to attend
5. Complete the registration information

After you have registered for the online training session, you will receive an email containing the toll-free phone number and meeting number, conference password, and a link to access the web portion of the session. **Please keep the registration email with the link to the Web conference and the call-in number for the session in which you will be participating.** This information will not be sent a second time in advance of the training.
New Prior Authorization Requirements

Effective March 1, 2020, MassHealth will require PA for the services and Current Procedural Terminology (CPT) codes listed below. Between March 1, 2020, and May 31, 2020, MassHealth will implement an informational edit that will not deny claims for services and codes requiring PA, but instead will inform providers of the PA requirement for those services and codes.

Beginning June 1, 2020, MassHealth will deny claims for services and codes requiring PA if the provider has not obtained PA. MassHealth and eviCore will provide technical assistance to providers during the rollout phase.

- **Turnaround Time:** eviCore will render a decision within 2 business days of a timely, complete request for PA.
- **Urgent and Emergent Care:** MassHealth is committed to ensuring patient access to necessary care and is working closely in partnership with eviCore to ensure that PA requests are processed in a timely manner and that there are appropriate processes in place to address urgent service needs. PA will not be required for services rendered in the emergency department, and there will be an option to submit same-day urgent PA requests, which will be processed within a maximum of 4 hours. If urgent requests meet medical necessity criteria and all required documentation is submitted, urgent requests can be approved in real time.
- **Window to Submit PA:** PA can be requested for a service rendered up to 14 days after the date of service.
- **Technical & Professional:** When a code requires a professional and a technical component (TC), PA is required for the technical component only, and the TC modifier must be included on the PA request.
- **Referrals:** If Primary Care Provider (PCP) referrals are required for the service requested, the PA will not override the referral requirement. For such services, MassHealth still requires a referral in addition to the PA.

Prior Authorization Denials and Appeals Process

If a PA request is lacking necessary documentation, eviCore will contact the provider to obtain the missing information. If the provider fails to submit the requested documentation within 10 days of eviCore’s request, eviCore will issue an administrative denial of the request for PA. Upon receipt of a timely, complete submission, eviCore will review and approve, deny, or modify the request within 2 business days.

Once eviCore has rendered a decision, eviCore will notify the provider by fax or eviCore’s web portal. If eviCore has denied or modified a PA request, eviCore will also notify the member of this fact by mail. This communication will also explain the member’s appeal rights and include an appeal form. The member will have 30 days to appeal that decision to the Board of Hearings (BOH).

If eviCore has denied or modified a request for PA, the provider may request a peer-to-peer consultation with an eviCore clinician to review the clinical aspects of the case. Providers may request such consultations through eviCore’s online portal. A provider’s request for a peer-to-peer consultation does not alter or enlarge the time in which the member can request a fair hearing related to the denial or modification of the prior authorization request.
If eviCore overturns the denial or modification after the peer-to-peer consultation, the provider will be notified through the web portal and eviCore will work with the member to withdraw any requests for a hearing through the BOH.

**Clinical Guidelines to Evaluate PA Requests**

eviCore’s Clinical Guidelines will be used to determine medical necessity and evaluate requests for PA by service category. Provider requests for authorization of the following services and codes must adhere to eviCore’s clinical guidelines, which are available on eviCore’s website and can be found at the following URL: [https://www.evicore.com/provider/clinical-guidelines](https://www.evicore.com/provider/clinical-guidelines).

**Advanced Imaging CPT Codes**

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Non-obstetric Ultrasound CPT Codes

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Cardiac Stress Tests CPT Codes

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Providers must submit clinical documentation with PA requests for these services. Follow the links below for further guidance.

[https://www.evicore.com/resources/healthplan/masshealth](https://www.evicore.com/resources/healthplan/masshealth)

To submit a PA request for these services, follow the link below.

[https://www.evicore.com/](https://www.evicore.com/)

MassHealth reviews requests for PA on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

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. No text in the body or subject line is needed.

Questions or Concerns

If you have any questions or concerns about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.
NEW MATERIAL
(The pages listed here contain new or revised language.)

Community Health Center Manual

Pages 6-1 through 6-22

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

Community Health Center Manual

Pages 6-1 through 6-22 — transmitted by Transmittal Letter CHC-112
Introduction and Explanation of Abbreviations

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

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

The following abbreviations are used in Subchapter 6.

(A) PA indicates that service-specific prior authorization is required. See 130 CMR 450.303 for more information.

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

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

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

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

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

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

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

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<sup>1</sup>PA is required for dates of service on or after March 1, 2020. If a code comprises both a professional component and a technical component, PA is required for the technical component only, and the TC modifier must be included on the PA request.
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603 Payable Laboratory Service Codes

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¹PA is required for dates of service on or after March 1, 2020. If a code comprises both a professional component and a technical component, PA is required for the technical component only, and the TC modifier must be included on the PA request.
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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.

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<th>Modifier</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4261</td>
<td></td>
<td>Cervical cap for contraceptive use (IC)</td>
</tr>
<tr>
<td>A4266</td>
<td></td>
<td>Diaphragm for contraceptive use (includes applicator and cream or jelly)</td>
</tr>
<tr>
<td>A4267</td>
<td></td>
<td>Contraceptive supply, condom, male, each</td>
</tr>
<tr>
<td>A4268</td>
<td></td>
<td>Contraceptive supply, condom, female, each</td>
</tr>
<tr>
<td>A4269</td>
<td></td>
<td>Contraceptive supply, spermicide (e.g., foam, gel), each (per package/tube)</td>
</tr>
<tr>
<td>D9450</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>J1050</td>
<td></td>
<td>Injection, medroxyprogesterone acetate, 1 mg (IC)</td>
</tr>
<tr>
<td>J3490</td>
<td></td>
<td>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)</td>
</tr>
<tr>
<td>J3490</td>
<td>FP</td>
<td>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. (IC)</td>
</tr>
<tr>
<td>J7296</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg</td>
</tr>
<tr>
<td>J7297</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration (IC)</td>
</tr>
<tr>
<td>J7298</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (IC)</td>
</tr>
<tr>
<td>J7300</td>
<td></td>
<td>Intrauterine copper contraceptive (use for Paragard) (IC)</td>
</tr>
<tr>
<td>J7301</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg (IC)</td>
</tr>
<tr>
<td>J7303</td>
<td></td>
<td>Contraceptive supply, hormone-containing vaginal ring, each (IC)</td>
</tr>
<tr>
<td>J7304</td>
<td></td>
<td>Contraceptive supply, hormone-containing patch, each (IC)</td>
</tr>
<tr>
<td>J7307</td>
<td></td>
<td>Etonogestrel (contraceptive) implant system, including implant and supplies (must be billed with either 11981 or 11983) (IC)</td>
</tr>
<tr>
<td>S4989</td>
<td></td>
<td>Contraceptive intrauterine device (e.g., Progestacet IUD), including implants and supplies (IC)</td>
</tr>
<tr>
<td>S4993</td>
<td></td>
<td>Contraceptive pills for birth control</td>
</tr>
<tr>
<td>G0469</td>
<td></td>
<td>Use for individual mental health visit, new patient (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>Service Code</td>
<td>Modifier</td>
<td>Special Requirement or Limitation</td>
</tr>
<tr>
<td>--------------</td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>G0470</td>
<td></td>
<td>Use for individual mental health visit, established patient. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>T1015</td>
<td></td>
<td>Use for individual medical visit.</td>
</tr>
<tr>
<td>T1015 HQ</td>
<td></td>
<td>Use for group clinic visit.</td>
</tr>
<tr>
<td>90791</td>
<td></td>
<td>Use for psychiatric diagnostic evaluation. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>90832</td>
<td></td>
<td>Use for psychotherapy, 30 minutes with patient and/or family member. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>90834</td>
<td></td>
<td>Use for psychotherapy, 45 minutes with patient and/or family member. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>90836</td>
<td></td>
<td>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)</td>
</tr>
<tr>
<td>90837</td>
<td></td>
<td>Use for psychotherapy, 60 minutes with patient and/or family. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>90853</td>
<td></td>
<td>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)</td>
</tr>
<tr>
<td>90882</td>
<td></td>
<td>Environmental intervention for medical management purposes on a psychiatric patient’s behalf with agencies, employers, or institutions. (This code can be billed via telehealth)</td>
</tr>
<tr>
<td>96130</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>96132</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>99050</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>99188</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>99402</td>
<td></td>
<td>Use for HIV counseling visits.</td>
</tr>
</tbody>
</table>
(B) This section lists evaluation and management visit service codes that are payable under MassHealth.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99218</td>
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<tr>
<td>99219</td>
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<td>99224</td>
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<tr>
<td>99225</td>
<td></td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90460</td>
<td></td>
</tr>
<tr>
<td>90461</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>90476</td>
<td>Adenovirus vaccine, type 4, live, for oral use (IC)</td>
</tr>
<tr>
<td>90477</td>
<td>Adenovirus vaccine, type 7, live, for oral use (IC)</td>
</tr>
<tr>
<td>90581</td>
<td>Anthrax vaccine, for subcutaneous or intramuscular use (IC)</td>
</tr>
<tr>
<td>90585</td>
<td>Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use</td>
</tr>
<tr>
<td>90620</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use. (IC)</td>
</tr>
<tr>
<td>90621</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 3 dose schedule, for intramuscular use. (IC)</td>
</tr>
<tr>
<td>90625</td>
<td>Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use, (IC)</td>
</tr>
<tr>
<td>90630</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90632</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90633</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90636</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90651</td>
<td>Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90654</td>
<td>Covered for adults &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>Service Code</td>
<td>Special Requirement or Limitation</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>90656</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.</td>
</tr>
<tr>
<td>90658</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90660</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90661</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90662</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90664</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90666</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90667</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90668</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90670</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90672</td>
<td>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)</td>
</tr>
<tr>
<td>90673</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90676</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90682</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90686</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90688</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90690</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90696</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90707</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90710</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90713</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. (IC)</td>
</tr>
<tr>
<td>90714</td>
<td>Covered for members &gt;19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
</tbody>
</table>
604 Payable Visit and Vaccine Service Codes (cont.)

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>90715</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90716</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90732</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.</td>
</tr>
<tr>
<td>90733</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90734</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age. (IC)</td>
</tr>
<tr>
<td>90736</td>
<td>PA is required for members &lt; age 50. (IC)</td>
</tr>
<tr>
<td>90738</td>
<td>Japanese encephalitis virus vaccine, inactivated, for intramuscular use (IC)</td>
</tr>
<tr>
<td>90739</td>
<td>Covered for members &gt; 19 (IC)</td>
</tr>
<tr>
<td>90746</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.</td>
</tr>
<tr>
<td>90749</td>
<td>Unlisted vaccine/toxoid (IC)</td>
</tr>
<tr>
<td>90750</td>
<td>PA is required for members &lt; age 50. (IC)</td>
</tr>
<tr>
<td>90756</td>
<td>Covered for members &gt; 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Fee-for-Service Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>59410</td>
</tr>
<tr>
<td>59414</td>
<td>59514</td>
</tr>
<tr>
<td>59515</td>
<td>59622</td>
</tr>
</tbody>
</table>

Global Deliveries

<table>
<thead>
<tr>
<th>Code</th>
<th>Global Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>59510</td>
</tr>
<tr>
<td>59510</td>
<td>59610</td>
</tr>
</tbody>
</table>

606 Payable Surgery Service Codes

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Payable Surgery Service Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11976</td>
<td>11982</td>
</tr>
<tr>
<td>11981</td>
<td>11983</td>
</tr>
<tr>
<td>Service Codes</td>
<td>Descriptions</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>19100</td>
<td>Payable Surgery Service Codes (cont.)</td>
</tr>
<tr>
<td>44955</td>
<td>58146</td>
</tr>
<tr>
<td>49082</td>
<td>58150 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>49083</td>
<td>58180 (HI-1 form required; PA or Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>49084</td>
<td></td>
</tr>
<tr>
<td>49255</td>
<td>58300</td>
</tr>
<tr>
<td>49320</td>
<td>58301</td>
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<tr>
<td>54050</td>
<td>58340</td>
</tr>
<tr>
<td>54057</td>
<td>58353</td>
</tr>
<tr>
<td>54150</td>
<td>58541 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>54160</td>
<td></td>
</tr>
<tr>
<td>55250 (CS-18 or CS-21 required) (SP)</td>
<td>58542 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>56420</td>
<td>58543 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>56440</td>
<td>58544 (HI-1 form required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>56501</td>
<td></td>
</tr>
<tr>
<td>56515</td>
<td></td>
</tr>
<tr>
<td>56605</td>
<td></td>
</tr>
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<td>57061</td>
<td>58555 (SP)</td>
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<td>57250</td>
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<td>57260</td>
<td>58562</td>
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<tr>
<td>57420</td>
<td>58565 (CS-18 or CS-21 required)</td>
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<tr>
<td>57421</td>
<td>58600 (CS-18 or CS-21 required)</td>
</tr>
<tr>
<td>57425</td>
<td>58605 (CS-18 or CS-21 required) (SP)</td>
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<tr>
<td>57452</td>
<td>58611 (CS-18 or CS-21 required)</td>
</tr>
<tr>
<td>57454</td>
<td>58615 (CS-18 or CS-21 required)</td>
</tr>
<tr>
<td>57455</td>
<td>58660</td>
</tr>
<tr>
<td>57456</td>
<td>58661 (CS-18* or CS-21* required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>57460</td>
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</tr>
<tr>
<td>57461</td>
<td></td>
</tr>
<tr>
<td>57500</td>
<td>58670 (CS-18 or CS-21 required)</td>
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<td>57505</td>
<td>58671 (CS-18 or CS-21 required)</td>
</tr>
<tr>
<td>57510</td>
<td>58700</td>
</tr>
<tr>
<td>57511</td>
<td>58720 (CS-18* or CS-21* required; PA for Gender Dysphoria-Related Services Only)</td>
</tr>
<tr>
<td>57513</td>
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<tr>
<td>57520</td>
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<tr>
<td>58140</td>
<td>59870</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Modifier</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>TH</td>
<td>Use for a medical visit with a nurse midwife for a prenatal or postpartum service.</td>
</tr>
<tr>
<td>59400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59409</td>
<td></td>
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<tr>
<td>59410</td>
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<tr>
<td>59414</td>
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<td></td>
</tr>
<tr>
<td>59614</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, Diagnostic 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 99392 99394

610 **Payable Early and Periodic Screening, Diagnostic 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.

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

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.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes.</td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (2 or more, per 30 minutes).</td>
</tr>
<tr>
<td>G0270</td>
<td>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.</td>
</tr>
</tbody>
</table>
612 Payable Medical Nutrition Therapy and Diabetes Self-Management Training Service Codes (cont.)

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0271</td>
<td>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.</td>
</tr>
<tr>
<td>97802</td>
<td>Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.</td>
</tr>
<tr>
<td>97803</td>
<td>Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes.</td>
</tr>
<tr>
<td>97804</td>
<td>Medical nutrition therapy; group (2 or more individuals), each 30 minutes</td>
</tr>
</tbody>
</table>

613 Payable Behavioral Health Screening Tool Service Codes

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

The administration and scoring of standardized behavioral health screening tools selected from the approved menu of tools found in Appendix W of your MassHealth provider manual is covered for members (except MassHealth Limited) from birth to 21 years of age. Service Code 96110 must be accompanied by one of the modifiers listed below to indicate whether a behavioral health need was identified.*

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Modifier</th>
<th>Special Requirement or Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>96110</td>
<td>U1</td>
<td>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.)</td>
</tr>
<tr>
<td>96110</td>
<td>U2</td>
<td>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.)</td>
</tr>
<tr>
<td>96110</td>
<td>U3</td>
<td>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.)</td>
</tr>
<tr>
<td>Service Code</td>
<td>Modifier</td>
<td>Special Requirement or Limitation</td>
</tr>
<tr>
<td>-------------</td>
<td>----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>96110 U4</td>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>96110 U5</td>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>96110 U6</td>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>96110 U7</td>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>96110 U8</td>
<td></td>
<td>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.)</td>
</tr>
<tr>
<td>96110 UD</td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

* “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.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Perinatal Care Provider – Positive Screen: completed prenatal or postpartum depression screening and behavioral health need identified.</td>
</tr>
<tr>
<td>U2</td>
<td>Perinatal Care Provider – Negative Screen: completed prenatal or postpartum depression screening with no behavioral health need identified.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>97810</td>
<td>97811</td>
<td>97813</td>
<td>97814</td>
</tr>
</tbody>
</table>

616 Modifiers

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Unrelated evaluation and management service by the same physician during a postoperative period</td>
</tr>
<tr>
<td>25</td>
<td>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</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
</tr>
<tr>
<td>58</td>
<td>Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team</td>
</tr>
</tbody>
</table>
616 **Modifiers** (cont.)

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>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</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
</tr>
<tr>
<td>91</td>
<td>Repeat clinical diagnostic laboratory test</td>
</tr>
<tr>
<td>99</td>
<td>Multiple modifiers</td>
</tr>
<tr>
<td>LT</td>
<td>Left side (used to identify procedures performed on the left side of the body)</td>
</tr>
<tr>
<td>QW</td>
<td>CLIA waived test</td>
</tr>
<tr>
<td>RT</td>
<td>Right side (used to identify procedures performed on the right side of the body)</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
</tr>
<tr>
<td>XE</td>
<td>Separate Encounter: a service that is distinct because it occurred during a separate encounter</td>
</tr>
<tr>
<td>XP</td>
<td>Separate Practitioner: a service that is distinct because it was performed by a different practitioner</td>
</tr>
<tr>
<td>XS</td>
<td>Separate Structure: a service that is distinct because it was performed on a separate organ/structure</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual Non-Overlapping Service: the use of a service that is distinct because it does not overlap usual components of the main service</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>Surgical or other invasive procedure on wrong body part</td>
</tr>
<tr>
<td>PB</td>
<td>Surgical or other invasive procedure on wrong patient</td>
</tr>
<tr>
<td>PC</td>
<td>Wrong surgery or other invasive procedure on patient</td>
</tr>
</tbody>
</table>

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

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