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

MassHealth
Transmittal Letter CHC-90
August 2011

TO: Community Health Centers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *Community Health Center Manual* (Revised Service Codes and Descriptions)

This letter transmits revisions to the service codes and descriptions in the *Community Health Center Manual* and informs providers about billing and payment rules that apply when community health center (CHC) physicians provide certain services at hospitals. These changes, including the revised Subchapter 6, are effective for dates of service on or after August 1, 2011. This letter also includes a reminder about the requirement to use the U-modifier for Service Code 96110, which is effective for dates of service on or after July 1, 2011.

Please Note: 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. A community health center (CHC) 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 the *Community Health Center Manual*.

For more information about payment, you may download the Division of Health Care Finance and Policy (DHCFP) regulations at no cost at www.mass.gov/dhcfp. You may also purchase a paper copy of the DHCFP regulations from either the Massachusetts State Bookstore or from DHCFP (see addresses and telephone numbers below). You must contact them first to find out the price of the paper copy of the publication. The regulation titles are as follows: 114.3 CMR 18.00: Radiology, 114.3 CMR 20.00: Clinical Laboratory Services, 114.3 CMR 4.00: Rates for Community Health Centers, 114.3 CMR 16.00: Surgery and Anesthesia, and 114.3 CMR 17.00: Medicine.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Expanded Obstetrics Services and Surgery Services

Effective for dates of service on or after August 1, 2011, MassHealth is adding expanded obstetrics services and surgery services codes to Subchapter 6 of the *Community Health Center Manual*. (See Section 605 for obstetrics service codes and descriptions. See Section 606 for surgery service codes and descriptions.)

When billing MassHealth for these services, CHCs must use the appropriate place-of-service-code. In order for the CHC to bill MassHealth for the expanded service codes, the services must be performed by a qualified physician who is an employee or contractor of the CHC, and is not receiving payment from a hospital or MassHealth for the same service. Claims submitted for payment by the CHC must clearly identify which services have been provided in the CHC and which services have been provided in a hospital setting. The CHC must maintain records that clearly account for the time a physician spends separately in the CHC and in a hospital setting. The CHC must make these records available for review by MassHealth staff upon request.

For payment information applicable to obstetric services, refer to 130 CMR 405.423 and 405.426.

MassHealth has recently developed new rules for the payment of surgical procedures that apply to the surgical procedures listed in Section 606 of Subchapter 6 of the *Community Health Center Manual.* Under the new policy, payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services included within the global surgical package are not payable separately, regardless of the setting in which those services are performed. The new rules appear in the *Physician Manual* at 130 CMR 433.451 and 433.452. In addition to a description of the global surgical package, the provisions in 130 CMR 433.451 and 433.452 describe payment for multiple surgeries and endoscopies, add-on surgical procedures, bilateral procedures, surgical assistants, team surgery, and co-surgery (two surgeons). Effective for dates of service on or after August 1, 2011, CHCs will be paid in accordance with the surgical services provisions in 130 CMR 433.451 and 433.452 when a CHC physician performs the surgical procedure in a hospital, subject to the following conditions.

- The CHC, and not the physician, must bill for and receive payment from MassHealth.
- In order for the CHC to bill for the service, the surgery services must be performed by a qualified physician who is an employee or contractor of the CHC and is not receiving payment from a hospital or MassHealth to perform the same service. The physician must be scrubbed and present in the operating room during the major portion of the operation.
- MassHealth pays a CHC for a visit, treatment, or procedure. MassHealth does not pay for both a preoperative visit, and a treatment or procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, MassHealth does not pay separately for a visit on the same day as the surgery or endoscopy.
- The surgery service codes for which MassHealth pays CHCs are listed in Section 606 of Subchapter 6 of the *Community Health Center Manual.* MassHealth does not pay CHCs for other surgery service codes.
- To receive payment for surgical assistants, the CHC must use the appropriate modifier, and the assistant surgeon must be an employee or contractor of the CHC, and not otherwise receiving a payment from the hospital or MassHealth for the same service.
- To receive payment for team surgery, the CHC must use the team surgery modifier, and all physician members of the surgical team must be employees or contractors of the CHC, and not otherwise receiving a payment from the hospital or MassHealth for the same service.
- To receive payment for two surgeons (co-surgery), the CHC must use the two surgeons modifier, and bill for both surgeons' services. Both surgeons must be employees or contractors of the CHC, and not otherwise receiving a payment from the hospital or MassHealth for the same service.

Modifiers applicable to the global surgical fee package and other rules referenced in 130 CMR 433.451 and 433.452 have been added to Section 614 of Subchapter 6 and are effective for dates of service on or after August 1, 2011.

Vaccines

Effective for dates of service on or after August 1, 2011, MassHealth is adding vaccine codes to Subchapter 6 of the *Community Health Center Manual* for:

- HPV (90649 and 90650) – for adults aged 19 through 26; and
- MMR (90707), IPV (90713), Tdap (90715), Varicella (90716), and PPV (90732) – for adults 19 years and older.

The above referenced vaccines are available free of charge through the Massachusetts Immunization Program for children under 19 years of age.

MassHealth is also adding a vaccine code for Zoster (shingles) (90736). For additional information and PA requirements, see Section 604 of Subchapter 6 of the *Community Health Center Manual.*

Critical Edit for Required Behavioral Health Screen Modifier

This is a reminder that, in May 2011, MassHealth issued All Provider Bulletin 211 (Critical Edit for Required Behavioral Health Screen Modifier). It stated that effective for dates of service on or after July 1, 2011, MassHealth denies claims that do not include a "U" modifier (U1~U8) with a claim for Service Code 96110. The claim will deny for Edit 8156 *"U" Modifier required for code 96110 – not present*.

Since December 31, 2007, MassHealth has required all CHCs serving MassHealth members under the age of 21 (except MassHealth Limited) to offer to use one of several standardized behavioral health screening tools when performing that component of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Pediatric Preventive Health-care Screening and Diagnosis (PPHSD) visit. The EPSDT Medical and Dental Periodicity Protocols and Schedules (Appendix W) of the *Community Health Center Manual* contains the menu of approved, clinically appropriate, standardized screening tools from which to choose.

MassHealth pays for the administration and scoring of the standardized behavioral health screening tool, separately from the office visit when using Service Code 96110 and the appropriate "U" modifier. MassHealth provided detailed information about these requirements in Transmittal Letter ALL-155, dated December 2007,which communicated updates to the EPSDT/PPHSD regulations (130 CMR 450.140 through 450.150), Appendix W, and Appendix Z**.**

The specific billing modifier to use depends on the type of provider conducting the screen and the disposition of the screen, see Section 613 of Subchapter 6 of the *Community Health Center Manual*. The clinician must exercise his or her professional judgment as to whether or not the screen identifies a potential behavioral health need.

CHCs must ensure that billing departments and fiscal intermediaries are aware of the implementation of and requirements for this critical edit in order to avoid denial of claims for a behavioral health screen using Service Code 96110. Please refer to All Provider Bulletin 211 for more information.

All applicable provisions of 130 CMR 405.000 and 130 CMR 450.000 continue to govern CHC participation in MassHealth.

Questions

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

NEW MATERIAL
(The pages listed here contain new or revised language)

Community Health Center Manual

Pages vi and 6-61 through 6-76

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

Community Health Center Manual

Pages vi and 6-61 through 6-74 — transmitted by Transmittal Letter CHC-89

6. Service Codes and Descriptions

603 Laboratory Service Codes and Descriptions (cont.)

Service Code	Service Description
94750	Pulmonary compliance study (e.g., plethysmography, volume and pressure measurements) (with report only) (S.P. to 94010, 94060, 94070, and 94620)
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination (no professional component) (S.P. to 94620)
94761	multiple determinations (e.g., during exercise) (no professional component) (S.P. to 94620)
94762	by continuous overnight monitoring (separate procedure) (no professional component) (S.P. to 94620)
94770	Carbon dioxide, expired gas determination by infrared analyzer (with report only) (S.P. to 94620)
94772	Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant (I.C.)
94774	Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation, and preparation of a report (I.C.)
94775	monitor attachment only (includes hook-up, initiation of recording and disconnection) (I.C.)
94776	monitoring, download of information, receipt of transmission(s) and analyses by computer only (I.C.)
94777	physician review, interpretation, and preparation of report only (I.C.)
94799	Unlisted pulmonary service or procedure (I.C.)

SUPPLEMENTARY

99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

604 Visit Service Codes and Descriptions

When claiming payment for visits, 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.)

Service Code	Modifier	Service Description
		CHC Visits
D1206		Topical fluoride varnish; therapeutic application for moderate-to-high caries risk patients.
D9450		Case presentation, detailed and extensive treatment planning (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.)
J3490		Unclassified drugs (Use for injectable and infusible drugs and devices supplied in the clinic. Do not use for medications and injectables related to family planning services.) (I.C.)
T1015		Clinic visit/encounter, all-inclusive (Use for individual medical visit.)
T1015	HQ	Clinic visit/encounter, all-inclusive, group setting (Use for group clinic visit.)
90632		Hepatitis A vaccine, adult dosage, for intramuscular use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
90649		Human Papiloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90650		Human Papiloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use (Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90707		Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90713		Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90715		Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use (Covered for adults > 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90716		Varicella virus vaccine, live, for subcutaneous use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90732		Pneumoccal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90736		Zoster (shingles) vaccine, live, for subcutaneous injection (I.C.) (P.A. is required for members < age 60)
90746		Hepatitis B vaccine, adult dosage, for intramuscular use (Covered for adults >19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age)
90899		Unlisted psychiatric service or procedure (Use for individual mental health visit.) (I.C.)
99050		Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g.. holidays, Saturday, or Sunday), in addition to basic service (Use for urgent care Monday through Friday from 5:00 P.M. to 6:59 A.M., and Saturday 7:00 A.M. to Monday 6:59 A.M. This code may be billed in addition to the individual medical visit.)
99402		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes (Use for HIV counseling visits.)
		Hospital Inpatient Services
99221		Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a detailed or comprehensive history; - a detailed or comprehensive examination; and - medical decision making that is straightforward or of low complexity.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
99222		Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity.
99223		Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity.
99460		Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant
		Subsequent Hospital Care
99231		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a problem focused interval history; - a problem focused examination; - medical decision making that is straightforward or of low complexity.
99232		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - an expanded problem focused interval history; - an expanded problem focused examination; - medical decision making of moderate complexity.
99233		Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of high complexity.
99462		Subsequent hospital care, per day, for evaluation and management of normal newborn
		HOSPITAL OBSERVATION SERVICES
		Initial Observation Care (New or Established Patient)
99218		Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: - a detailed or comprehensive history; - a detailed or comprehensive examination; and - medical decision making that is straightforward or of low complexity.
99219		Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
99220		Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity.
		Subsequent Observation Care
99224		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - problem focused interval history; - problem focused examination; - medical decision making that is straightforward or of low complexity.
99225		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - an expanded problem focused interval history; - an expanded problem focused examination; - medical decision making of moderate complexity.
99226		Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of high complexity.
		Nursing Facility Services
99304		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: - a detailed or comprehensive history; - a detailed or comprehensive examination; and - medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99305		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
99306		Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.
99307		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a problem focused interval history; - a problem focused examination; - straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.
99308		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - an expanded problem-focused interval history; - an expanded problem-focused examination; - medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
99309		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99310		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a comprehensive interval history; - a comprehensive examination; - medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES		
		New Patient
99324		Domicillary or rest home visit for the evaluation and management of a new patient, which requires these three key components: - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.
99325		Domicillary or rest home visit for the evaluation and management of a new patient, which requires these three components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
99326		Domicillary or rest home visit for the evaluation and management of a new patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.
99327		Domicillary or rest home visit for the evaluation and management of a new patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
		Established Patient
99334		Domicillary or rest home visit for the evaluation and management of an established patient, which requires at least two these three key components: - a problem-focused interval history; - a problem-focused examination; - straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.
99335		Domicillary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three components: - an expanded problem-focused interval history; - an expanded problem-focused examination; - medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.
99336		Domicillary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three components: - a detailed interval history; - a detailed examination; - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.
99337		Domicillary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive interval history; - a comprehensive examination; - medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

604 Visit Service Codes and Descriptions (cont.)

Service Code	Modifier	Service Description
		HOME SERVICES
		New Patient
99341		Home visit for the evaluation and management of a new patient, which requires these three key components: - a problem focused history; - a problem focused examination; and - straightforward medical decision making.
99342		Home visit for the evaluation and management of a new patient, which requires these three key components: - an expanded problem focused history; - an expanded problem focused examination; and - medical decision making of low complexity.
99343		Home visit for the evaluation and management of a new patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity.
99345		Home visit for the evaluation and management of a new patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity. (I.C.)
		Established Patient
99347		Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a problem focused interval history; - a problem focused examination; - straightforward medical decision making.
99348		Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem focused interval history; - an expanded problem focused examination; - medical decision making of low complexity.
99349		Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of moderate complexity.
99350		Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive interval history; - a comprehensive examination; - medical decision making of moderate to high complexity. (I.C.)

605 Obstetrics Service Codes and Descriptions

See 130 CMR 405.422 through 405.426 for other requirements.

Service Code	Service Description
	Fee-for-Service Deliveries
59409	Vaginal delivery only (with or without episiotomy and/or forceps
59410	including postpartum care
59414	Delivery of placenta (separate procedure)
59514	Cesarean delivery only
59515	including postpartum care
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)(Hysterectomy Information (HI-1) form required)
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	including postpartum care
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	including postpartum care
	Global Deliveries
59400	Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59618	Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

606 Surgery Service Codes and Descriptions

Service Code	Service Description
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure.)
49255	Omentectomy, epiploectomy, resection of omentum (separate procedure)
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
54057	Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) (Consent for Sterilization Form (CS-18 or CS-21) required) (S.P.)
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) (Consent for Sterilization Form (CS-18 or CS-21) required)(S.P.)
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst

606 Surgery Service Codes and Descriptions (cont.)

Service Code	Service Description
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy
57260	Combined anteroposterior colporrhaphy
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	loop electrode excision
57700	Cerclage of uterine cervix, nonobstetrical
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) (Hysterectomy Information (HI-1) form required)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s) (Hysterectomy Information (HI-1) form required)
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less (Hysterectomy Information (HI-1) form required)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g (Hysterectomy Information (HI-1) form required)
58544	with removal of tube(s) and/or ovary(s) (Hysterectomy Information (HI-1) form required)
58555	Hysteroscopy, diagnostic (separate procedure)
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58560	with division or resection of intrauterine septum (any method)
58561	with removal of leiomyomata
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral (Consent for Sterilization Form (CS-18 or CS-21) required)
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure) (Consent for Sterilization Form (CS-18 or CS-21) required) (S.P.)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (Consent for Sterilization Form (CS-18 or CS-21) required) (List separately in addition to code for primary procedure.)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring), vaginal or suprapubic approach (Consent for Sterilization Form (CS-18 or CS-21) required)
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) (Consent for Sterilization Form (CS-18 or CS-21) required)
58670	with fulguration of oviducts (with or without transection) (Consent for Sterilization Form (CS-18 or CS-21) required)
58671	with occlusion of oviducts by device (e.g., band, clip, or Falope ring) (Consent for Sterilization Form (CS-18 or CS-21) required)

606 Surgery Service Codes and Descriptions (cont.)

Service Code	Service Description
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
59000	Amniocentesis, diagnostic
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling, any method
59025	Fetal non-stress test
59870	Uterine evacuation and curettage for hydatidiform mole

607 Nurse-Midwife Service Codes and Descriptions

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	Service Description
T1015	TH	Clinic visit/encounter, all-inclusive – obstetrical treatment/services, prenatal or postpartum (use for a medical visit with a nurse midwife for a prenatal or postpartum service)
59400		Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409		Vaginal delivery only (with or without episiotomy and/or forceps)
59410		including postpartum care
59414		Delivery of placenta (separate procedure)
59610		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59612		Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614		including postpartum care

608 Audiology Service Codes and Descriptions

See 130 CMR 405.461 through 405.463 for other requirements.

Service Code	Service Description
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	air and bone
92567	Tympanometry (impedance testing)

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

See 130 CMR 450.140 through 450.149 for other requirements.

Service Code	Service Description
	New Patient
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; infant (age younger than one year)
99382	early childhood (age one through four years)
99383	late childhood (age five through 11 years)
99384	adolescent (age 12 through 17 years)
99385	18 through 39 years
	Established Patient
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age younger than one year)
99392	early childhood (age one through four years)
99393	late childhood (age five through 11 years)
99394	adolescent (age 12 through 17 years)
99395	18 through 39 years

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

Service Code	Service Description
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
99173	Screening test of visual acuity, quantitative, bilateral.

611 Tobacco Cessation Service Codes and Descriptions

Service Code	Modifier	Service Description
99407		Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) (Eligible providers are physicians employed by community health centers.)
99407	HN	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) (Eligible providers are physicians employed by community health centers.)

611 Tobacco Cessation Service Codes and Descriptions (cont)

Service Code	Modifier	Service Description
99407	HQ	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (for an individual in a group setting, 60-90 minutes) (Eligible providers are physicians employed by community health centers.)
99407	SA	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) (Eligible providers are nurse practitioners employed by community health centers.)
99407	SB	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) (Eligible providers are nurse midwives employed by community health centers.)
99407	TD	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) (Eligible providers are registered nurses employed by community health centers.)
99407	TF	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (intake assessment for an individual, at least 45 minutes) (Eligible providers are physicians employed by community health centers.)
99407	U1	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (at least 30 minutes) Eligible providers are tobacco cessation counselors employed by community health centers.)
99407	U2	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (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	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (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 Medical Nutrition Therapy and Diabetes Self-Management Training Service Codes and Descriptions

Service Code	Service Description
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, group session (two 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 the 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 (two or more individuals), each 30 minutes
97802	Medical nutrition therapy, initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

612 Medical Nutrition Therapy and Diabetes Self-Management Training Service Codes and Descriptions (cont)

Service Code	Service Description
97803	reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	group (two or more individuals), each 30 minutes

613 Behavioral Health Screening Tool Service Codes and Descriptions

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

Service Code	Modifier	Service Description
96110	U1	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are physicians employed by community health centers)
96110	U2	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are physicians employed by community health centers)
96110	U3	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are nurse midwives employed by community health centers)
96110	U4	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are nurse midwives employed by community health centers)
96110	U5	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are nurse practitioners employed by community health centers)

613 Behavioral Health Screening Tool Service Codes and Descriptions

Service Code	Modifier	Service Description
96110	U6	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are nurse practitioners employed by community health centers)
96110	U7	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are physician assistants employed by community health centers)
96110	U8	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report; 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 need identified* (eligible providers are physician assistants employed by community health centers)

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

614 Modifiers

The following service code modifiers are allowed for billing under MassHealth for CHCs in conjunction with Surgery Services.

Modifier	Modifer Description
50	Bilateral procedure
51	Multiple procedures
54	Surgical care only
62	Two surgeons
66	Surgical team
80	Assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
99	Multiple modifiers

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