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

MassHealth
Transmittal Letter FPA-51
January 2015

TO: Family Planning Agencies Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Family Planning Agency Manual* (Updated Sterilization Provisions and Subchapter 6)

Sterilization Provisions

This letter transmits revisions to the sterilization provisions in the family planning agency regulations. MassHealth has updated certain sterilization provisions in the family planning regulations for consistency purposes with other MassHealth provider regulations, and to make conforming changes to reflect that both male and female sterilizations occur for family planning agencies. These changes continue to conform to federal standards.

Please see 130 CMR 421.438 through 421.440 and relevant definitions for more information and the applicable sterilization provisions.

This letter also transmits a Consent for Sterilization form (CS-18 or CS-21) coding update to Subchapter 6 of the *Family Planning Agency Manual*.

Additional Updates to Subchapter 6

This letter transmits certain additional revisions to Subchapter 6 of the *Family Planning Agency Manual.*

The following Preventive Medicine, Individual Counseling service code has been added and should be used for a counseling visit of 15 minutes or less.

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes

The following service code has been added and should be used when billing for the medroxyprogesterone acetate contraceptive injection.

- J1050 Injection, medroxyprogesterone acetate, 1 mg

The following intrauterine device (IUD) service code has been added and should be used when billing for the brand of device specified in parentheses.

- J7301 Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg

The following service code has been added and should be used in conjunction with billing for long-acting removable contraceptives (e.g., IUDs, subdermal implants).

- 11982 Removal, non-biodegradable drug delivery implant

The following service code has been added and should be used for the destruction of penile lesions.

- 54050 Destruction of lesions(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical

Modifier 25 has also been added to Section 606 of Subchapter 6. Please refer to the All Provider Bulletin 227 RE: Modifier Coverage and National Correct Coding Initiative (NCCI) Updates for information on appropriate use of the modifier.

Effective Date

All regulatory amendments and Subchapter 6 updates described in this letter are effective for dates of service on or after January 2, 2015.

If you wish to obtain a fee schedule, you may download the Executive Office of Health and Human Services regulations at no cost at www.mass.gov/eohhs. The pricing regulation title for Family Planning Services is 101 CMR 312.00.

MassHealth Website

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

Questions

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

NEW MATERIAL

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

Family Planning Agency Manual

Pages iv, vi, 4-1, 4-2, 4-7, 4-8, 4-13 through 4-16, and 6-1 through 6-14

OBSOLETE MATERIAL

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

Family Planning Agency Manual

Pages iv, 4-1, 4-2, and 4-13 through 4-16 — transmitted by Transmittal Letter FPA-39

Page vi — transmitted by Transmittal Letter FPA-49

Pages 4-7, 4-8, and 6-1 through 6-14 — transmitted by Transmittal Letter FPA-50

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421.401: Introduction

All providers of family planning agency services participating in MassHealth must comply with the MassHealth regulations at 130 CMR 421.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

421.402: Definitions

The following terms used in 130 CMR 421.000 have the meanings given in 130 CMR 421.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 421.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 421.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Annual Visit – a yearly visit during which comprehensive services, including medical, laboratory, and counseling services are provided.

HIV Pre- and Post-Test Counseling Visit – a face-to-face meeting between the member and a counselor for the purpose of providing counseling before and after HIV testing. Such counseling includes information about the implications of positive and negative test results, risk-reduction techniques, partner notification, and referral to medical and support services, in accordance with established protocols of the Massachusetts Department of Public Health.

Initial Visit – a member's first visit during which comprehensive services, including medical, laboratory, and counseling services are provided.

Institutionalized Individual – an individual who is

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

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

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

Minimal Visit – a brief visit during which a family planning agency provides counseling services only or brief medical and counseling services.

Routine Visit – a return visit, follow-up visit, or other visit that is neither an annual nor an initial visit.

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

421.403: Eligible Members

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

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

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

421.404: Provider Eligibility

Payment for the services described in 130 CMR 421.000 is made only to family planning agencies that are participating in MassHealth as of the date of service. The eligibility requirements for family planning agencies are as follows.

(A) In State.

(1) A family planning agency located in Massachusetts is eligible to participate in MassHealth only if it is certified by the MassHealth agency as a family planning agency, in accordance with the requirements specified in 130 CMR 421.404 through 421.427.

(2) The family planning agency must fulfill one of the following licensing requirements.

(a) Family planning services must be provided in a facility licensed as a clinic or hospital by the Massachusetts Department of Public Health.

(b) Family planning services must be provided under the supervision of a physician licensed by the Massachusetts Board of Registration in Medicine.

(3) A family planning agency may provide family planning services in one or more service delivery sites, which must be located in freestanding clinics, community health centers, hospital outpatient departments, or hospital-licensed health centers.

(B) Out of State. A family planning agency located outside of Massachusetts is eligible to participate in MassHealth only if it meets the licensing requirements in its state, participates in that state's Medicaid program (or equivalent), and meets the requirements specified in 130 CMR 421.404 through 421.427.

421.405: Staffing

(A) Personnel Policies.

(1) Current job descriptions must be available for all positions of the staff.

(2) Written personnel policies must be available to all personnel.

(3) An evaluation and review of the job performance of all personnel must be conducted annually.

421.417: Noncovered Services

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

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

The MassHealth agency pays for all medically necessary family planning services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction through 450.149: EPSDT: Recordkeeping Requirements*, without regard to service limitations described in 130 CMR 421.000, and with prior authorization.

(130 CMR 421.419 through 421.420 Reserved)

421.421: Coordination of Services

When a family planning agency is located in a community health center, a hospital, or another primary-care setting, the agency must demonstrate that family planning services are coordinated with and integrated into other services delivered on site. Such coordination includes at a minimum:

(A) either one central medical record for each member in which all medical and health-care services are recorded, or a mechanism for transferring relevant information to medical records to ensure continuity of care;

(B) avoidance of duplication of medical examinations and laboratory tests; and

(C) in-house referrals, as appropriate.

421.422: Emergency Backup

A family planning agency must have provisions for 24-hour emergency backup. Each member must be given the emergency telephone number in writing at the time of initiation of services. The telephone number must also be displayed prominently in the family planning agency.

421.423: Recordkeeping Requirements

(A) Payment for any service listed in 130 CMR 421.000 is conditioned upon its full and complete documentation in the member's medical record. A family planning agency must maintain a record of all medical and contraceptive services provided to a member for at least six years following the date of service. Every member visit or telephone call with the staff must be recorded. The documentation must include the reason for each visit or telephone call and any action taken.

(B) The medical record must contain, but is not limited to, the following information:
(1) the member's name, address, telephone number, date of birth, and MassHealth identification number;
(2) the date of service;
(3) the name, title, and signature of the person performing the service or making the contact;
(4) the type of visit (for example, annual or routine);
(5) medical history and history update;
(6) pertinent findings on examination;
(7) laboratory tests and results;
(8) abnormal findings and follow-up treatment;
(9) drugs administered or prescribed, including strength, dosage, route, regimen, and number of refills;
(10) drugs dispensed, including strength, dosage, route, regimen, and number of units;
(11) the contraceptive method used and any special instructions;
(12) a summary of counseling; and
(13) plans for follow-up.

(C) Basic information collected during previous visits with the member (for example, identifying data or medical history) does not need to be repeated in the medical record for subsequent visits as long as the entire medical record reflects continuity of care.

421.434: Payment: Contraceptive Supplies and Drugs

(A) Contraceptive Supplies. The MassHealth agency pays for contraceptive supplies listed in Subchapter 6 of the *Family Planning Agency Manual*. If the family planning agency purchases supplies at a price lower than that allowed in the fee schedule, the agency must bill the MassHealth agency at that lower price.

(B) Drugs. The MassHealth agency pays for drugs at the actual acquisition cost. A copy of the current invoice showing the actual acquisition cost must be attached to the claim form. Claims for dispensing drugs must include the following information: the name of the drug; the strength; the dosage; and the number of units. Claims without this information will be denied. Payment for drugs is determined on an individual consideration (I.C.) basis by the MassHealth agency, based on the information entered on the claim.

(130 CMR 421.435 through 421.437 Reserved)

421.438: Sterilization Services: Introduction

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

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 421.439, and such consent is documented in the manner described in 130 CMR 421.440.

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

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

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

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 421.438(A) are met.

(D) Location in Which Sterilizations May Be Performed. Sterilizations must be performed by a licensed physician at the family planning agency's site.

421.439: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent was obtained in accordance with the requirements specified in 130 CMR 421.439(A) and (B), and such consent is documented as specified in 130 CMR 421.440.

(A) Informed Consent Requirements.

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

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

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is considered irreversible;

(d) a thorough explanation of the specific sterilization procedure to be performed;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days from the date consent is given, except in the circumstances specified in 130 CMR 421.439(B)(1).

(2) The person who obtains consent must also
(a) offer to answer any questions the member may have about the sterilization procedure;
(b) give the member a copy of the consent form;
(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 421.439(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;
(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and
(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.
(1) A member's consent for sterilization will be considered informed and voluntary only if such consent was obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 421.439. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
(2) A member's consent for sterilization will not be considered informed or voluntary if such consent was obtained or given while the member requesting sterilization is
(a) in labor or childbirth;
(b) seeking to obtain or obtaining an abortion; or
(c) under the influence of alcohol or other substances that affect the individual's state of awareness.
(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 421.439(A)(1).

421.440: Sterilization Services: Consent Form Requirements

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

(A) Required Consent Form.
(1) One of the following Consent for Sterilization forms must be used:
(a) CS-18 – for members aged 18 through 20; or
(b) CS-21 – for members aged 21 and older.
(2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

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

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

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

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

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

REGULATORY AUTHORITY

130 CMR 421.000: M.G.L. c. 118E, §§ 7 and 12.

601 Definitions and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

(A) New Patient — a patient who has not received any professional services from the provider within the past three years.

(B) Established Patient — a patient who has received professional services from the provider within the past three years.

(C) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services— 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 421.000 and 450.000. A family planning agency provider 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 *Family Planning Agency Manual*.

602 Service Codes and Descriptions: Visits

Service Code	Service Description
	New Patient
99201	Office or other outpatient 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
99202	Office or other outpatient 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 - straightforward medical decision making
99203	Office or other outpatient 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 low complexity
99204	Office or other outpatient 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
99205	Office or other outpatient 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

602 Service Codes and Descriptions: Visits (cont.)

Service Code	Service Description
	Established Patient
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health-care professional. Usually the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services (minimal service)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a problem-focused history; - a problem-focused examination; - straightforward medical decision making
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; - medical decision making of low complexity (limited service)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a detailed history; - a detailed examination; - medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - a comprehensive history; - a comprehensive examination; - medical decision making of high complexity (comprehensive service)
	Preventive Medicine, New Patient
99384	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 laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	18-39 years
99386	40-64 years
	Preventive Medicine, Established Patient
99394	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 laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	18-39 years
99396	40-64 years

602 Service Codes and Descriptions: Visits (cont.)

Service Code	Service Description
	Preventive Medicine, Individual Counseling
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	approximately 30 minutes (HIV pre- and post-test counseling only; two visits per day; maximum eight visits per year)

603 Service Codes and Descriptions: Contraceptive Supplies and Drugs

90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), three-dose schedule, for intramuscular use (I.C.)
90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, three-dose schedule, for intramuscular use
A4261	Cervical cap for contraceptive use (I.C.)
A4266	Diaphragm for contraceptive use (includes applicator and cream or jelly)
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each (per package/tube)
J1050	Injection, medroxyprogesterone acetate, 1 mg
J3490-FP	Unclassified drugs (Use for medications and injectables related to family planning services, with the exception of (a) Rh_o(D) human immune globulin; and (b) contraceptive injectables such as Depo-Provera, items for which MassHealth will pay the provider's cost.) (I.C.)
J7300	Intrauterine copper contraceptive (use for Paragard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (use for Mirena)
J7303	Contraceptive supply, hormone-containing vaginal ring, each
J7304	Contraceptive supply, hormone-containing patch, each
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies (must be billed with either 11981 or 11983)
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (I.C.)
S4993	Contraceptive pills for birth control

604 Service Codes and Descriptions: Medical and Surgery Procedures

11976	Removal, implantable contraceptive capsules (S.P.)
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49083	with imaging guidance
49084	Peritoneal lavage, including imaging guidance, when performed
54050	Destruction of lesions(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical

604 Service Codes and Descriptions: Medical and Surgery Procedures (cont.)

Service Code	Service Description
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) (Consent for Sterilization form CS-18 or CS-21 required)
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure) (Consent for Sterilization form CS-18 or CS-21 required)
56420	Incision and drainage of Bartholin's gland abscess
56501	Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	Biopsy of vulva or perineum (separate procedure); one lesion
57061	Destruction of vaginal lesion(s); simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)
57100	Biopsy of vaginal mucosa; simple (separate procedure)
57420	Colposcopy of the entire vagina, with cervix if present
57421	with biopsy(ies) of vagina/cervix
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57452	Colposcopy of the cervix including upper/adjacent vagina
57454	with biopsy(ies) of the cervix and endocervical curettage
57455	with biopsy(ies) of the cervix
57456	with endocervical curettage
57460	with loop electrode biopsy(ies) of the cervix
57461	with loop electrode conization of the cervix
57500	Biopsy of cervex, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505	Endocervical curettage (not done as part of a dilation and curettage)
57510	Cautery of cervix; electro or thermal
57511	cryocautery, initial or repeat
57513	laser ablation
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
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)
58340	Catherization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Consent for Sterilization form CS-18 or CS-21 required.)

605 Service Codes and Descriptions: Laboratory Services

ORGAN OR DISEASE-ORIENTED PANELS

These panels were developed for coding purposes only and should not be interpreted as clinical parameters. The tests listed with each panel identify the defined components of that panel. These panel components are not intended to limit the performance of other tests. If one performs tests in addition to those specifically indicated for a particular panel, those tests should be reported separately in addition to the panel code.

Service Code	Service Description
80055	Obstetric panel (This panel must include the following: blood count, complete (CBC), automated, and automated differential WBC count (85025 or 85027 and 85004) or blood count, complete (CBC), automated (85027), and appropriate manual differential WBC count (85007 or 85009); hepatitis B surface antigen (HBsAg) (87340); antibody, rubella (86762); syphilis test, non-treponemal antibody, qualitative (e.g., VDRL, RPR, ART) (86592); antibody screen, RBC, each serum technique (86850); blood typing, ABO (86900); and blood typing, Rh (D) (86901).)
80061	Lipid panel (This panel must include the following: cholesterol, serum, total (82465); lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718); and triglycerides (84478).)
80074	Acute hepatitis panel (This panel must include the following: hepatitis A antibody (HAAb); IgM antibody (86709); hepatitis B core antibody (HbcAb), IgM antibody (86705); hepatitis B surface antigen (HbsAg) (87340); and hepatitis C antibody (86803).)
80076	Hepatic function panel (This panel must include the following: albumin (82040); bilirubin, total (82247); bilirubin, direct (82248); phosphatase, alkaline (84075); protein, total (84155); transferase, alanine amino (ALT) (SGPT) (84460); and transferase, aspartate amino (AST) (SGOT) (84450).)

URINALYSIS

81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; nonautomated, with microscopy
81001	automated, with microscopy
81002	nonautomated, without microscopy
81003	automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	bacteriuria screen, except by culture or dipstick
81025	Urine pregnancy test, by visual color comparison methods
81099	Unlisted urinalysis procedure

CHEMISTRY

The material for examination may be from any source unless otherwise specified in the code description. The examination is quantitative unless specified. Clinical information derived from the results of laboratory data that is mathematically calculated (e.g., free thyroxine index (T7)) is considered part of the test procedure and therefore is not a separately reportable service.

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
82040	Albumin; serum, plasma, or whole blood
82247	Bilirubin; total
82248	direct
82270	Blood, occult; by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)
82310	Calcium; total
82465	Cholesterol, serum or whole blood, total
82540	Creatine
82550	Creatine kinase (CK), (CPK); total
82565	Creatinine; blood
82570	other source
82607	Cyanocobalamin (vitamin B-12)
82627	Dehydroepiandrosterone-sulfate (DHEA-S)
82670	Estradiol
82671	Estrogens; fractionated
82672	total
82677	Estriol
82679	Estrone
82746	Folic acid; serum
82947	Glucose; quantitative, blood (except reagent strip)
82950	post-glucose dose (includes glucose)
82951	tolerance test (GTT), three specimens (includes glucose)
82955	Glucose-6-phosphate dehydrogenase (G6PD); quantitative
82960	screen
83001	Gonadotropin; follicle-stimulating hormone (FSH)
83002	luteinizing hormone (LH)
83003	Growth hormone, human (HGH) (somatotropin)
83036	glycosylated (A1C)
83491	Hydroxycorticosteroids, 17- (17-OHCS)
83540	Iron
83550	Iron-binding capacity
83586	Ketosteroids, 17- (17-KS); total
83593	fractionation
83615	Lactate dehydrogenase (LD), (LDH)
83625	isoenzymes, separation and quantitation
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
84060	Phosphatase, acid; total
84066	prostatic
84075	Phosphatase, alkaline
84078	heat stable (total not included)
84080	isoenzymes
84132	Potassium; serum, plasma or whole blood
84144	Progesterone

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
84146	Prolactin
84155	Protein, total, except by refractometry; serum, plasma or whole blood
84156	urine
84157	other source (e.g., synovial fluid, cerebrospinal fluid)
84160	Protein, total, by refractometry, any source
84163	Pregnancy-associated plasma protein-A (PAPP-A)
84165	Protein; electrophoretic fractionation and quantitation, serum
84166	electrophoretic fractionation and quantitation, other fluids with concentration (e.g., urine, CSF)
84295	Sodium; serum, plasma or whole blood
84300	urine
84402	Testosterone; free
84403	total
84436	Thyroxine; total
84437	requiring elution (e.g., neonatal)
84439	free
84443	Thyroid-stimulating hormone (TSH)
84450	Transferase; aspartate amino (AST) (SGOT)
84460	alanine amino (ALT) (SGPT)
84478	Triglycerides
84479	Thyroid hormone (T3 or T4) uptake or thyroid hormone binding ratio (THBR)
84480	Triiodothyronine T3; total (TT-3)
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
84590	Vitamin A
84702	Gonadotropin, chorionic (hCG); quantitative
84703	qualitative

HEMATOLOGY AND COAGULATION

85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	blood smear, microscopic examination without manual differential WBC count
85009	manual differential WBC count, buffy coat
85013	spun microhematocrit
85014	hematocrit (Hct)
85018	hemoglobin (Hgb)
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
85041	red blood cell (RBC), automated
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte; nonautomated
85652	automated
85660	Sickling of RBC, reduction

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
	IMMUNOLOGY
86038	Antinuclear antibodies (ANA)
86171	Complement fixation tests, each antigen
86235	Extractable nuclear antigen, antibody to, any method (e.g., nRNP, SS-A, SS-B, Sm, RNP, Sc170, J01), each antibody
86280	Hemagglutination inhibition test (HAI)
86308	Heterophile antibodies; screening
86309	titer
86310	titers after absorption with beef cells and guinea pig kidney
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (e.g., reagent strip)
86592	Syphilis test, nontreponemal antibody; qualitative (e.g., VDRL, RPR, ART)
86593	quantitative

The following codes (86628–86804) are qualitative or semi-quantitative immunoassays performed by multiple-step methods for the detection of antibodies to infectious agents. For immunoassays by single-step method (e.g., reagent strips), use code 86318. Procedures for the identification of antibodies should be coded as precisely as possible. For example, an antibody to a virus could be coded with increasing specificity for virus, family, genus, species, or type. In some cases, further precision may be added to codes by specifying the class of immunoglobulin being detected. When multiple tests are done to detect antibodies to organisms classified more precisely than the specificity allowed by available codes, code each as a separate service. For example, a test for antibody to an enterovirus is coded as 86658. Coxsackieviruses are enteroviruses, but there are no codes for the individual species of enterovirus. If assays are performed for antibodies to coxsackie A and B species or for antibodies of different immunoglobulin classes, each assay should be separately coded. When a coding option exists for reporting IgM specific antibodies (e.g., 86632) the corresponding nonspecific code (e.g., 86631) may be reported for performance of either an antibody analysis not specific for a particular immunoglobulin class or an IgG analysis.

86628	Antibody; Candida
86631	Chlamydia
86632	Chlamydia, IgM
86687	HTLV-I
86688	HTLV-II
86689	HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86692	hepatitis, delta agent
86694	herpes simplex, nonspecific type test
86695	herpes simplex, type 1
86696	herpes simplex, type 2
86701	HIV-1
86702	HIV-2
86703	HIV-1 and HIV-2, single result

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
86704	Hepatitis B core antibody (HBcAb); total
86705	IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86708	Hepatitis A antibody (HAAb); total
86709	IgM antibody
86762	Antibody; rubella
86803	Hepatitis C antibody
86804	confirmatory test (e.g., immunoblot)

TRANSFUSION MEDICINE

86850	Antibody screen, RBC, each serum technique
86900	Blood typing; ABO
86901	Rh (D) (I.C.)
86906	Rh phenotyping, complete

MICROBIOLOGY

87070	Culture, bacterial; any other source except urine, blood, or stool, aerobic, with isolation and presumptive identification of isolates
87075	any source; except blood, anaerobic with isolation and presumptive identification of isolates
87081	Culture, presumptive, pathogenic organisms, screening only
87086	Culture, bacterial; quantitative colony count, urine
87088	with isolation and presumptive identification of each isolate, urine
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail
87102	other source (except blood)
87103	blood
87110	Culture, Chlamydia, any source
87140	Culture, typing; immunofluorescent method, each antiserum
87164	Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection
87177	Ova and parasites, direct smears, concentration and identification
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (e.g., antibiotic gradient strip)
87184	disk method, per plate (12 or fewer agents)
87186	microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multiantimicrobial, per plate
87188	macrobroth dilution method, each agent
87205	Smear, primary source; with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87206	fluorescent and/or acid-fast stain for bacteria, fungi, parasites, viruses, or cell types
87207	special stain for inclusion bodies or parasites (e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses)

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
87210	wet mount for infectious agents (e.g., saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (e.g., scabies)
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87253	tissue culture, additional studies or definitive identification (e.g., hemabsorption, neutralization, immunofluoresence stain), each isolate

Infectious agents by antigen detection, immunofluorescence microscopy, or nucleic acid probe techniques should be reported as precisely as possible. The most specific code possible should be reported. For identification of antibodies to many of the listed infectious agents, see 86602-86804.

87270	Infectious agent antigen detection by immunofluorescent technique; chlamydia trachomatis
87273	Herpes simplex virus type 2
87274	Herpes simplex virus type 1
87285	Treponema pallidum
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis
87340	hepatitis B surface antigen (HBsAg)
87350	hepatitis Be antigen (HBeAg)
87380	hepatitis, delta agent
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result
87390	HIV-1
87391	HIV-2
87480	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87481	Candida species, amplified probe technique
87482	Candida species, quantification
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87492	Chlamydia trachomatis, quantification
87510	Gardnerella vaginalis, direct probe technique
87511	Gardnerella vaginalis, amplified probe technique
87512	Gardnerella vaginalis, quantification
87515	hepatitis B virus, direct probe technique
87516	hepatitis B virus, amplified probe technique
87517	hepatitis B virus, quantification
87520	hepatitis C, direct probe technique
87521	hepatitis C, amplified probe technique, includes reverse transcription when performed
87522	hepatitis C, quantification, includes reverse transcription when performed
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87530	Herpes simplex virus, quantification
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique, includes reverse transcription when performed

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
87536	HIV-1, quantification, includes reverse transcription when performed
87537	HIV-2, direct probe technique
87538	HIV-2, amplified probe technique, includes reverse transcription when performed
87539	HIV-2, quantification, includes reverse transcription when performed
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87592	Neisseria gonorrhoeae, quantification
87620	papillomavirus, human, direct probe technique
87621	papillomavirus, human, amplified probe technique
87622	papillomavirus, human, quantification
87631	respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets
87632	respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 6-11 targets
87633	respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets
87810	Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850	Neisseria gonorrhoeae
87910	Infectious agent genotype analysis by nucleic acid (DNA or RNA); cytomegalovirus
87912	Hepatitis B virus

ANATOMIC PATHOLOGY

CYTOPATHOLOGY

88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
88106	simple filter method with interpretation
88108	Cytopathology, concentration technique, smears and interpretation (e.g., Saccomanno technique)
88112	Cytopathology, selective cellular enhancement technique with interpretation (e.g., liquid-based slide preparation method), except cervical or vaginal
88130	Sex chromatin identification; Barr bodies

Codes 88141–88155, 88164–88167, and 88174–88175 are used to report cervical or vaginal screening by various methods and to report physician interpretation services. Use codes 88150–88154 to report conventional Pap smears that are examined using non-Bethesda reporting. Use codes 88164–88167 to report conventional Pap smears that are examined using the Bethesda System of reporting. Use codes 88142–88143 to report liquid-based specimens processed as thin-layer preparations that are examined using any system of reporting (Bethesda or non-Bethesda).

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description

Within each of these three code families choose the one code that describes the screening method(s) used. Codes 88141 and 88155 should be reported in addition to the screening code chosen when the additional services are provided. Manual rescreening requires a complete visual assessment of the entire slide initially screened by either an automated or manual process. Manual review represents as assessment of selected cells or regions of a slide identified by initial automated review.

88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service.)
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin-layer preparation; manual screening under physician supervision
88143	with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	with manual screening and computer-assisted rescreening under physician supervision
88153	with manual screening and rescreening under physician supervision
88154	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services.)
88160	Cytopathology, smears, any other source; screening and interpretation
88161	preparation, screening, and interpretation
88162	extended study involving over five slides and/or multiple stains (I.C.)
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	with manual screening and rescreening under physician supervision
88166	with manual screening and computer-assisted rescreening under physician supervision
86167	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88199	Unlisted cytopathology procedure (I.C.)

CYTOGENETIC STUDIES

88261	Chromosome analysis; count five cells, one karyotype, with banding
88262	count 15 to 20 cells, two karyotypes, with banding
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotype, with banding
88280	Chromosome analysis; additional karyotypes, each study
88285	additional cells counted, each study

605 Service Codes and Descriptions: Laboratory Services (cont.)

Service Code	Service Description
	SURGICAL PATHOLOGY
	Codes 88300 through 88309 are further clarified in the *Current Procedural Terminology* (CPT) code book.
88300	Level I - surgical pathology, gross examination only
88302	Level II - surgical pathology, gross and microscopic examination
88304	Level III - surgical pathology, gross and microscopic examination
88305	Level IV - surgical pathology, gross and microscopic examination
88307	Level V - surgical pathology, gross and microscopic examination
88309	Level VI - surgical pathology, gross and microscopic examination
	OTHER PROCEDURES
89050	Cell count, miscellaneous body fluids (e.g., cerebrospinal fluid, joint fluid), except blood
	REPRODUCTIVE MEDICINE PROCEDURES
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	motility and count (not including Huhner test)
89320	volume, count, motility, and differential
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner

606 Modifiers

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

Modifier	Description
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the day of the procedure or other service
59	Distinct procedural service
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)

606 Modifiers (cont.)

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

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

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