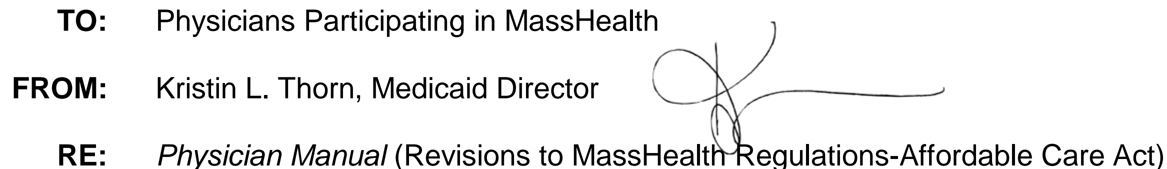
*Commonwealth of Massachusetts*
*Executive Office of Health and Human Services*
*Office of Medicaid*
*www.mass.gov/masshealth*

MassHealth
Transmittal Letter PHY-140
December 2013

**TO:** Physicians Participating in MassHealth

**FROM:** Kristin L. Thorn, Medicaid Director



**RE:** *Physician Manual* (Revisions to MassHealth Regulations-Affordable Care Act)

This letter transmits revised regulations and an updated Subchapter 6 of the *Physician Manual*.

The revised regulations and Subchapter 6 implement changes in coverage for acupuncture and the diagnosis of infertility. These changes were prompted by requirements of the Affordable Care Act regarding coverage of Essential Health Benefits.

These regulations are effective January 1, 2014. The revised Subchapter 6 is effective for dates of service on or after January 1, 2014.

**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 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.)

Physician Manual

Pages iv, iv-a, 4-1, 4-2, 4-7, 4-8, 4-33 through 4-42, 4-45, 4-46, and 6-1 through 6-24

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(The pages listed here are no longer in effect.)

Physician Manual

Pages iv, 4-1, 4-2, 4-7, 4-8, 4-39, and 4-40 — transmitted by Transmittal Letter PHY-124

Page iv-a — transmitted by Transmittal Letter PHY-131

Pages 4-33 and 4-34 — transmitted by Transmittal Letter PHY-111

Pages 4-35 through 4-38 — transmitted by Transmittal Letter PHY-122

Pages 4-41 and 4-42 — transmitted by Transmittal Letter PHY-135

Pages 4-45 and 4-46 — transmitted by Transmittal Letter PHY-137

Pages 6-1 through 6-24 — transmitted by Transmittal Letter PHY-139

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Part 1. General Information

433.401: Definitions

The following terms used in 130 CMR 433.000 have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 433.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 433.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Acupuncture – the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Adult Office Visit – a medical visit by a member 21 years of age or older to a physician's office or to a hospital outpatient department.

Child and Adolescent Needs and Strengths (CANS) – a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members younger than 21 years old.

Community-Based Physician – any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician.

Consultant – a licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a member's illness or disability.

Consultation – a visit made at the request of another physician.

Controlled Substance – a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery – a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to physical disease or defect, or traumatic injury.

Couple Therapy – therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service – a radiology service intended to identify an injury or illness.

Domiciliary – for use in the member's place of residence, including a long-term-care facility.

Drug – a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency Admission Service – a complete history and physical examination by a physician of a member admitted to a hospital to treat an emergency medical condition, when definitive care of the member is assumed subsequently by another physician on the day of admission.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in §1867(e)(1)(B) of the Social Security Act, 42 U.S.C. §1395dd(e)(1)(B).

Emergency Services – medical services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

Family Planning – any medically approved means, including diagnosis, treatment, and related counseling, that helps individuals of childbearing age, including sexually active minors, to determine the number and spacing of their children.

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

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

High-Risk Newborn Care – care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

Home or Nursing Facility Visit – a visit by a physician to a member at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital-Based Entity – any entity that contracts with a hospital to provide medical services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Based Physician – any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital to provide services to members on the same site as the hospital's inpatient facility or hospital-licensed health center.

Hospital-Licensed Health Center – a facility that

(1) operates under a hospital's license but is not physically attached to the hospital;
(2) operates within the fiscal, administrative, and clinical management of the hospital;
(3) provides services to patients solely on an outpatient basis;
(4) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
(5) is enrolled with the MassHealth agency as a hospital-licensed health center with a separate hospital-licensed health center MassHealth provider number.

(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the MassHealth agency before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the MassHealth agency a written request detailing the proposed treatment and naming the treatment facility (see the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The MassHealth agency will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the MassHealth agency will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.

(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

(5) Under comparable circumstances, the physician does not customarily bill private patients who do not have health insurance.

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

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

(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

The MassHealth agency pays for physician services with rates set by the Executive Office of Health and Human Services (EOHHS), subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000. EOHHS fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

(A) 114.3 CMR 14.00: Dental Services

(B) 101 CMR 315.00: Vision Care Services and Ophthalmic Services

(C) 114.3 CMR 16.00: Surgery and Related Anesthesia Services

(D) 101 CMR 317.00: Medicine

(E) 114.3 CMR 18.00: Radiology

(F) 114.3 CMR 20.00: Clinical Laboratory Services

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. See 130 CMR 433.410 for report requirements.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician or by an independent clinical laboratory certified by Medicare.

(B) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(B)(2), the MassHealth agency pays a physician only for laboratory tests performed in the physician's office. If a physician uses the services of an independent clinical laboratory, the MassHealth agency pays only the laboratory for services provided for a member.

(2) A physician may bill the MassHealth agency for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following:

(1) a signed request for the laboratory services to be performed;

(2) the member's MassHealth identification number; and

(3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the MassHealth agency will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per member specimen, regardless of the number of tests to be performed on that specimen.

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.
(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.
(a) The group of tests is designated as a profile or panel by the physician performing the tests.
(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.
(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:
(1) tests performed to establish paternity;
(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and
(3) post-mortem examinations.

433.440: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 433.440(C), for use as an anesthetic as described in 130 CMR 433.454(C), and for use for detoxification as described in 130 CMR 418.406(C)(3): *Acupuncture Detoxification*.

(B) General. 130 CMR 433.440 applies specifically to physicians and licensed practitioners of acupuncture.

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

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

(E) Conditions of Payment. The MassHealth agency pays physicians, physician employers of an acupuncturist (in accordance with 130 CMR 433.401(F)), independent nurse practitioners licensed in acupuncture, or independent nurse midwives licensed in acupuncture for acupuncture services when the:
(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 243 CMR 5.00: *The Practice of Acupuncture*);

(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and
(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.
(1) Physicians, independent nurse practitioners licensed in acupuncture, and independent nurse midwives licensed in acupuncture may submit claims for acupuncture services when they provide those services directly to MassHealth members or as an exception to 130 CMR 450.301(A) when a licensed practitioner under the supervision of a physician provides those services directly to MassHealth members. See Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.
(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the physician, independent nurse practitioner licensed in acupuncture, or independent nurse midwife licensed in acupuncture may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

433.441: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. The MassHealth agency pays for prescription drugs, over-the-counter drugs, and items listed on the Non-Drug Product List only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, for drugs in Schedules II through V must contain the prescriber's unique DEA number. For Schedule VI drugs, if the prescriber has no DEA registration number, the prescriber's Massachusetts Controlled Substance Registration number must appear on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.
(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.
(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described at 130 CMR 433.441(C)(3), or where the MassHealth Drug List specifically limits the number of refills, duration of the prescription, or both.
(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 433.441(D).
(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.
(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.
(6) The MassHealth agency does not pay for any refill without an explicit request from a

member or caregiver for each filling event. The possession by a provider of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

(D) Quantities.

(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed in a 30-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 433.441(D)(2).

(2) Exceptions to Days' Supply Limitations.

(a) The MassHealth agency allows exceptions to the limitations described in 130 CMR 433.441(D)(1) for the following products:

(i) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(ii) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;

(iii) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(iv) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 30-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);

(v) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments);

(vi) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs); and

(vii) methylphenidate and amphetamine prescribed in 60-day supplies;

(b) Drugs paid for by a member's primary insurance carrier that are dispensed in up to a 90-day supply when the MassHealth agency pays any portion of the claim, including the copayment portion or deductible, may be dispensed in up to a 90-day supply.

(c) Drugs used for family planning may be dispensed in up to a 90-day supply.

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the provider. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

(F) Excluded, Suspended, or Terminated Clinicians. The MassHealth agency does not pay for prescriptions written by clinicians

(1) who have been excluded from participation based on a notice by the U.S. Department of Health and Human Services Office of Inspector General; or

(2) whom the MassHealth agency has suspended, terminated, or denied admission into its program for any other reason.

433.442: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the following rules apply.

(1) Prescription Drugs. The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services

pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with DHCFP regulations at 114.3 CMR 31.00: Prescribed Drugs.
(2) Over-the-Counter Drugs. Payment by the MassHealth agency for over-the-counter drugs is calculated in accordance with DHCFP regulations at 114.3 CMR 31.00: Prescribed Drugs.

(B) Non-drug Products Paid Through POPS.
(1) The MassHealth agency pays through POPS, only for those products not classified as drugs that are listed on the non-drug product section of the MassHealth Drug List.
(2) Non-drug Product List. Payment for these items is in accordance with rates published in the Division of Health Care Finance and Policy regulations at 114.3 CMR 22.00: Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment and 101 CMR 317.00: Medicine. The MassHealth Non-Drug Product List also specifies which of the included products require prior authorization.

433.443: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless
(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 433.444); and
(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of prescription or over-the-counter drugs or drug therapy.
(1) Cosmetic. The MassHealth agency does not pay for any drug used for cosmetic purposes or for hair growth.
(2) Cough and Cold. The MassHealth agency does not pay for any drug used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient, unless dispensed to a member who is a resident in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).
(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.
(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.
(5) Less-Than-Effective Drugs. The MassHealth agency does not pay for any drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.
(6) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.
(7) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for any drug when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.
(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 433.443(B). The limitations and exclusions in 130 CMR 433.443(B) do not apply to medically necessary

drugs for MassHealth Standard enrollees under age 21. The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 433.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. (See 130 CMR 450.303: *Prior Authorization*.)

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for any drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307: *Unacceptable Billing Practices*.

433.444: Pharmacy Services: Insurance Coverage

(A) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107: *Eligible Members and the MassHealth Card* and 450.117: *Managed Care Participation*.

(B) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 433.443(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 *et seq*.

(C) Medicare Part D.

(1) Overview. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any

Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.

(2) Medicare Part D One-Time Supplies. The MassHealth agency pays for one-time supplies of prescribed medications if the medication is a MassHealth-covered medication and the MassHealth member would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies. The MassHealth agency pays for the one-time supplies in all instances in which the pharmacist cannot bill a Medicare Part D prescription drug plan at the time the prescription is presented.

The MassHealth agency pays for a one-time 72-hour supply of prescribed medications.

(3) Cost-Sharing Assistance for MassHealth Members Enrolled in a Medicare Part D Prescription Drug Plan. For the purpose of 130 CMR 433.444(C)(3)(a) and (b), the "applicable MassHealth copayment" is the copayment the MassHealth member would pay for prescription drugs if the drugs were covered by MassHealth and not covered by Medicare Part D. MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment or deductible in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, must pay the applicable MassHealth copayment and the MassHealth agency pays the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

433.445: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 433.442(A) and 433.443(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the MassHealth agency for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*. If the MassHealth agency approves the request, it will notify the pharmacy and the member.

(C) The MassHealth agency will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) The MassHealth agency acts on requests for prior authorization for a drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

(E) The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 406.000. MassHealth evaluates the prior-authorization status of drugs on an ongoing basis, and updates the MassHealth Drug List accordingly.

433.446: Pharmacy Services: Member Copayments

Under certain conditions, the MassHealth agency requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether prescription or over-the-counter) covered by MassHealth. The copayment requirements are detailed in 130 CMR 450.130.

433.447: Pharmacy Services: Payment

Drugs and biologicals dispensed in the office are payable, subject to the service limitations at 130 CMR 433.404, 433.406, and 433.443. The MassHealth agency does not pay a physician separately for drugs that are considered routine and integral to the delivery of a physician's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the physician's fee for the service. The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the physician has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization. Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of units dispensed. A copy of the invoice showing the actual acquisition cost must be attached to the claim form for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, and must include the National Drug Code (NDC). Claims without this information are denied. The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge. Payment for drugs may be claimed in addition to an office visit.

(130 CMR 433.448 Reserved)

433.449: Fluoride Varnish Services

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

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

(C) Billing for an Office Visit and Fluoride Varnish Treatment or Procedure. A physician may bill for fluoride varnish services provided by the physician or a qualified staff member as listed in 130 CMR 433.449(B) under the supervision of a physician. The physician may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(D) Claims Submission. Physicians and independent nurse practitioners may submit claims for fluoride varnish services when they provide those services directly to MassHealth members. These are the only MassHealth provider types who may bill for this service independently under 130 CMR 433.449. A physician may also submit claims for fluoride varnish services that are provided by nurse practitioners, registered nurses, licensed practical nurses, physician assistants, and medical assistants according to 130 CMR 433.449(C). See Subchapter 6 of the *Physician Manual* for service codes.

(130 CMR 433.450 Reserved)

Part 3. Surgery Services

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency pays a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(B)(2) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for

(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries;
(2) 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;
(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury;
(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;
(5) services otherwise identified in MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and
(6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 433.451 and 433.452, unless otherwise indicated.

(1) Complications Following Surgery – all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.

(2) Evaluation and Management (E/M) Services – visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.

(3) Intraoperative Services – intraoperative services that are normally a usual and necessary part of a surgical procedure.

(4) Major Surgery – a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines the preoperative period is one day and the postoperative period is 90 days.

(5) Minor Surgery – a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or 10 days.

(6) Postoperative Period –

(a) The postoperative period for major surgery is 90 days.

(b) The postoperative period for minor surgery and endoscopies is zero or 10 days.

(7) Postoperative Visits – follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.

(8) Postsurgical Pain Management – postsurgical pain management by the surgeon, including supplies.

(9) Preoperative Period –

(a) The preoperative period for major surgery is one day.

(b) The preoperative period for minor surgery is zero days.

(10) Preoperative Visits – preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

433.452: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Physician Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 450.000.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency pays a physician for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy. For payment information about obstetrical care, refer to 130 CMR 433.421.

(3) Submitting Claims for Certified Registered Nurse-Anesthetists. As an exception to 130 CMR 450.301(A), a physician or group practice who is an employer of or who contracts with a CRNA, may submit claims for services provided by a CRNA, but only if such services are provided in accordance with 130 CMR 450.301(B). Only one provider may claim payment for the services provided by the CRNA.

(C) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture as a substitute for conventional surgical anesthesia.

433.455: Abortion Services

(A) Payable Services.

(1) The MassHealth agency pays for an abortion service if both of the following conditions are met:

(a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and

(b) the abortion is performed in accordance with M.G.L. c. 112, §§12K through 12U, except as provided under 130 CMR 433.455(C)(2).

(2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one that, according to the medical judgment of a licensed physician, is necessary in light of all factors affecting the woman's health.

(3) Unless otherwise indicated, all abortions referred to in 130 CMR 433.455 are payable abortions as defined in 130 CMR 433.455(A)(1) and (2).

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of abortion services. The MassHealth agency, any provider, or any agent or employee of a provider must not mislead any member into believing that a decision to have or not to have an abortion 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 abortion services as well as for all other medical services covered by MassHealth.

(C) Locations in Which Abortions May Be Performed. Abortions must be performed in compliance with the following.

(1) First-Trimester Abortion. A first-trimester abortion must be performed by a licensed and qualified physician in a clinic licensed by the Department of Public Health to perform surgical services, or in a hospital licensed by the Department of Public Health to perform medical and surgical services.

(2) Second-Trimester Abortion. A second-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform medical and surgical services; provided, however, that up to and including the $18^{th}$ week of pregnancy, a second-trimester abortion may be performed in a clinic that meets the requirements of 130 CMR 433.455(C)(1) where the attending physician certifies in the medical record that, in his or her professional judgment, a nonhospital setting is medically appropriate in the specific case.

(3) Third-Trimester Abortion. A third-trimester abortion must be performed by a licensed and qualified physician only in a hospital licensed by the Department of Public Health to perform abortions and to provide facilities for obstetric services.

(D) Certification for Payable Abortion Form. All physicians must complete a Certification for Payable Abortion (CPA-2) form and retain the form in the member's record. (Instructions for obtaining the Certification for Payable Abortion form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, specified in 42 CFR 449.100 through 449.109, the MassHealth agency must secure on the CPA-2 form the certifications described in 130 CMR 433.455(D)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(D)(1), (2), or (3), the certification described in 130 CMR 433.455(D)(4) is required on the CPA-2 form. The physician must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Mother Would Be Endangered. The attending physician must certify that, in the physician's professional judgment, the life of the mother would be endangered if the pregnancy were carried to term.

(2) Severe and Long-Lasting Damage to Mother's Physical Health. The attending physician and another physician must each certify that, in his or her professional judgment, severe and long-lasting damage to the mother's physical health would result if the pregnancy were carried to term. At least one of the physicians must also certify that he or she is not an "interested physician," defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The physician is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending physician must certify that, in his or her medical judgment, for reasons other than those described in 130 CMR 433.455(D)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the mother's health.

433.456: Sterilization Services: Introduction

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

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 433.457, and such consent is documented in the manner described in 130 CMR 433.458.

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

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

601 Introduction

MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology (CPT) 2013* code book for the descriptions for the service codes when billing for services provided to MassHealth members. MassHealth pays for all medicine, radiology, surgery, and anesthesia CPT codes in effect at the time of service, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 450.000, **except** for those codes listed in Section 602 of this subchapter, CPT Category II codes ending in F, and CPT Category III codes ending in T.

A physician may request prior authorization 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 *Physician Manual*.

- Section 602 lists CPT codes that are **not payable** under MassHealth.
- Section 603 lists CPT codes that have special requirements or limitations. Beside each service code in Section 603 is an explanation of the requirement or limitation.
- Section 604 lists Level II HCPCS codes that are payable under MassHealth.
- Section 605 lists service code modifiers allowed under MassHealth.

602 Nonpayable CPT Codes

Regardless of nonpayable status, a physician may request prior authorization for any medically necessary service for a MassHealth Standard or CommonHealth member younger than 21 years of age.

MassHealth does **not** pay for services billed under the following codes.

| | | | | |
|---|---|---|---|---|
| 10040 | 15825 | 21123 | 36416 | 43752 |
| 11922 | 15826 | 21245 | 36468 | 43842 |
| 11950 | 15828 | 21246 | 36469 | 43843 |
| 11951 | 15829 | 21248 | 36591 | 43845 |
| 11952 | 15847 | 21249 | 36592 | 44132 |
| 11954 | 15876 | 22526 | 36598 | 44705 |
| 15775 | 15877 | 22527 | 38204 | 44715 |
| 15776 | 15878 | 22841 | 38207 | 47133 |
| 15780 | 15879 | 22856 | 38208 | 47143 |
| 15781 | 17340 | 22861 | 38209 | 47144 |
| 15782 | 17360 | 22864 | 38210 | 47145 |
| 15783 | 17380 | 32491 | 38211 | 48160 |
| 15786 | 19355 | 32850 | 38212 | 48550 |
| 15787 | 19396 | 32855 | 38213 | 48551 |
| 15788 | 20930 | 32856 | 38214 | 50300 |
| 15789 | 20936 | 33930 | 38215 | 50323 |
| 15792 | 20985 | 33933 | 41870 | 50325 |
| 15793 | 21120 | 33940 | 41872 | 54900 |
| 15819 | 21121 | 33944 | 43206 | 54901 |
| 15824 | 21122 | 36415 | 43252 | 55200 |

602 Nonpayable CPT Codes (cont.)

55300
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88007

602 Nonpayable CPT Codes (cont.)

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| --- | --- | --- | --- | --- |
| 88012 | 89353 | 90997 | 95131 | 98961 |
| 88014 | 89354 | 90999 | 95132 | 98962 |
| 88016 | 89356 | 91112 | 95133 | 98966 |
| 88020 | 89398 | 91132 | 95134 | 98967 |
| 88025 | 90281 | 91133 | 95824 | 98968 |
| 88027 | 90283 | 92314 | 95965 | 98969 |
| 88028 | 90284 | 92315 | 95966 | 99001 |
| 88029 | 90287 | 92316 | 95967 | 99002 |
| 88036 | 90384 | 92317 | 95992 | 99024 |
| 88037 | 90386 | 92325 | 96000 | 99026 |
| 88040 | 90389 | 92352 | 96001 | 99027 |
| 88045 | 90396 | 92353 | 96002 | 99053 |
| 88099 | 90586 | 92354 | 96003 | 99056 |
| 88125 | 90633 | 92355 | 96004 | 99058 |
| 88333 | 90634 | 92358 | 96040 | 99060 |
| 88334 | 90644 | 92371 | 96101 | 99071 |
| 88738 | 90645 | 92531 | 96102 | 99075 |
| 88749 | 90646 | 92532 | 96103 | 99078 |
| 89250 | 90647 | 92533 | 96105 | 99080 |
| 89251 | 90648 | 92534 | 96111 | 99082 |
| 89253 | 90669 | 92548 | 96116 | 99090 |
| 89254 | 90680 | 92559 | 96118 | 99091 |
| 89255 | 90698 | 92560 | 96119 | 99100 |
| 89257 | 90700 | 92561 | 96120 | 99116 |
| 89258 | 90702 | 92562 | 96125 | 99135 |
| 89259 | 90708 | 92564 | 96150 | 99140 |
| 89260 | 90710 | 92597 | 96151 | 99143 |
| 89261 | 90712 | 92605 | 96152 | 99144 |
| 89264 | 90720 | 92606 | 96153 | 99145 |
| 89268 | 90721 | 92613 | 96154 | 99148 |
| 89272 | 90723 | 92615 | 96155 | 99149 |
| 89280 | 90743 | 92617 | 96376 | 99150 |
| 89281 | 90744 | 92630 | 96567 | 99172 |
| 89290 | 90748 | 92633 | 96902 | 99190 |
| 89291 | 90845 | 93660 | 96904 | 99191 |
| 89321 | 90863 | 93668 | 97005 | 99192 |
| 89322 | 90865 | 93770 | 97006 | 99241 |
| 89325 | 90875 | 93786 | 97014 | 99242 |
| 89329 | 90876 | 94005 | 97537 | 99243 |
| 89330 | 90880 | 94015 | 97545 | 99244 |
| 89331 | 90885 | 94644 | 97546 | 99245 |
| 89335 | 90889 | 94645 | 97755 | 99251 |
| 89342 | 90901 | 95012 | 98940 | 99252 |
| 89343 | 90911 | 95052 | 98941 | 99253 |
| 89344 | 90940 | 95120 | 98942 | 99254 |
| 89346 | 90989 | 95125 | 98943 | 99255 |
| 89352 | 90993 | 95130 | 98960 | 99288 |

602 Nonpayable CPT Codes (cont.)

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|---|---|---|---|---|
| 99315 | 99366 | 99406 | 99456 | 99505 |
| 99316 | 99367 | 99408 | 99485 | 99506 |
| 99339 | 99368 | 99409 | 99486 | 99507 |
| 99340 | 99374 | 99411 | 99487 | 99509 |
| 99354 | 99375 | 99412 | 99488 | 99510 |
| 99355 | 99377 | 99420 | 99489 | 99511 |
| 99356 | 99378 | 99429 | 99495 | 99512 |
| 99357 | 99379 | 99441 | 99496 | 99601 |
| 99358 | 99380 | 99443 | 99500 | 99602 |
| 99359 | 99401 | 99444 | 99501 | 99605 |
| 99360 | 99402 | 99450 | 99502 | 99606 |
| 99363 | 99403 | 99442 | 99503 | 99607 |
| 99364 | 99404 | 99455 | 99504 | |

603 Codes That Have Special Requirements or Limitations

The service codes in this section are payable by MassHealth, subject to all conditions and limitations in MassHealth regulations at 130 CMR 433.000 and 450.000, but require specific attachments or prior authorization, or have other specific instructions or limitations. Refer to Section 604 for specific requirements or limitations for HCPCS Level II codes.

**Legend**

Centrifuging required: Service Code 99000 may be used only to pay a physician who centrifuges and mails a specimen to a laboratory for analysis. (See 130 CMR 433.439.)

Covered for members ≥12: This code is payable only for members aged 12 years or older; available free of charge through the Massachusetts Immunization Program for children under 12 years of age.

Covered for members 19 to 26: This code is payable only for members aged 19 to 26 years; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.

Covered for members birth to 21: This code is payable only for members aged birth to 21 years; used to claim for the administration and scoring of a standardized behavioral health screening tool from the approved menu of tools found in Appendix W of your provider manual, must be accompanied by modifiers found in Section 605 under Modifiers for Behavioral Health Screening.

Covered for members ≥ 19: This code is payable only for members aged 19 or older; available free of charge through the Massachusetts Immunization Program for children under 19 years of age.

CPA-2: A completed Certification of Payable Abortion Form must be completed for all induced abortions, except medically induced abortions. See 130 CMR 450.234 through 450.260 and 130 CMR 433.455 for more information.

CS-18: A completed Sterilization Consent Form (for members aged 18 through 20) must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.456 through 433.458 for more information.

CS-21: A completed Sterilization Consent Form (for members aged 21 and older) must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.456 through 433.458 for more information.

603 Codes That Have Special Requirements or Limitations (cont.)

HI-1: A completed Hysterectomy Information Form must be completed. See 130 CMR 450.234 through 450.260 and 130 CMR 433.459 for more information.

IC: Claim requires individual consideration. See 130 CMR 433.406 for more information.

PA for OMT > 20: Prior authorization is required for more than 20 osteopathic manipulative therapy visits in a 12-month period.

PA for OT > 20: Prior authorization is required for more than 20 occupational therapy visits in a 12-month period.

PA for PT > 20: Prior authorization is required for more than 20 physical therapy visits, regardless of modality, in a 12-month period.

PA for ST > 35: Prior authorization is required for more than 35 speech/language therapy visits in a 12-month period.

PA for Units > 8: Prior authorization is required for claims submitted with greater than 8 units on a given date of service.

PA: Service requires prior authorization. See 130 CMR 433.408 for more information.

Urgent Care Only: Service Codes 99050 and 99051 may be used only for urgent care provided in the office after hours, in addition to the basic service.

| Service Code and Req. or Limit | |
|---|---|
| 01999 | IC |
| 11920 | PA |
| 11921 | PA |
| 15820 | PA |
| 15821 | PA |
| 15822 | PA |
| 15823 | PA |
| 15830 | PA |
| 15832 | PA |
| 15833 | PA |
| 15834 | PA |
| 15835 | PA |
| 15836 | PA |
| 15837 | PA |
| 15838 | PA |
| 15839 | PA |
| 15999 | IC |
| 17999 | IC |
| 19300 | PA |
| 19316 | PA |
| 19318 | PA |
| 19324 | PA |
| 19325 | PA |
| 21198 | PA |

| Service Code and Req. or Limit | |
|---|---|
| 19328 | PA |
| 19350 | PA |
| 19499 | IC |
| 20999 | IC |
| 21085 | PA |
| 21088 | IC |
| 21089 | IC |
| 21137 | PA |
| 21138 | PA |
| 21139 | PA |
| 21146 | PA |
| 21147 | PA |
| 21150 | PA |
| 21151 | PA |
| 21154 | PA |
| 21155 | PA |
| 21159 | PA |
| 21160 | PA |
| 21172 | PA |
| 21175 | PA |
| 21188 | PA |
| 21193 | PA |
| 21194 | PA |
| 21195 | PA |
| 21196 | PA |
| 21206 | PA |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code and Req. or Limit | |
| --- | --- |
| 21208 | PA |
| 21209 | PA |
| 21210 | PA |
| 21215 | PA |
| 21230 | PA |
| 21235 | PA |
| 21240 | PA |
| 21242 | PA |
| 21243 | PA |
| 21244 | PA |
| 21247 | PA |
| 21255 | PA |
| 21256 | PA |
| 21299 | PA; IC |
| 21499 | IC |
| 21742 | IC |
| 21743 | IC |
| 21899 | IC |
| 22857 | PA |
| 22862 | PA |
| 22865 | PA |
| 22899 | IC |
| 22999 | IC |
| 23929 | IC |
| 24940 | IC |
| 24999 | IC |
| 25999 | IC |
| 26989 | IC |
| 27299 | IC |
| 27599 | IC |
| 27899 | IC |
| 28890 | PA |
| 28899 | IC |
| 29799 | IC |
| 29800 | PA |
| 29804 | PA |
| 29999 | IC |
| 30400 | PA |
| 30410 | PA |
| 30420 | PA |
| 30430 | PA |
| 30435 | PA |
| 30450 | PA |
| 30999 | IC |

| Service Code and Req. or Limit | |
| --- | --- |
| 31299 | IC |
| 31599 | IC |
| 31899 | IC |
| 32851 | PA |
| 32852 | PA |
| 32853 | PA |
| 32854 | PA |
| 32999 | IC |
| 33935 | PA |
| 33945 | PA |
| 33981 | IC |
| 33982 | IC |
| 33983 | IC |
| 33999 | IC |
| 36299 | IC |
| 36470 | PA |
| 36471 | PA |
| 37501 | IC |
| 37799 | IC |
| 38129 | IC |
| 38230 | PA |
| 38240 | PA |
| 38241 | PA |
| 38242 | PA |
| 38589 | IC |
| 38999 | IC |
| 39499 | IC |
| 39599 | IC |
| 40799 | IC |
| 40840 | PA |
| 40842 | PA |
| 40843 | PA |
| 40844 | PA |
| 40845 | PA |
| 40899 | IC |
| 41599 | IC |
| 41820 | PA; IC |
| 41821 | IC |
| 41850 | IC |
| 41899 | IC |
| 42280 | PA |
| 42281 | PA |
| 42299 | IC |
| 42699 | IC |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code | Req. or Limit |
| --- | --- |
| 42999 | IC |
| 43289 | IC |
| 43499 | IC |
| 43644 | PA |
| 43645 | PA |
| 43647 | PA; IC |
| 43648 | IC |
| 43659 | IC |
| 43770 | PA |
| 43771 | PA |
| 43772 | PA |
| 43773 | PA |
| 43774 | PA |
| 43775 | PA |
| 43846 | PA |
| 43847 | PA |
| 43848 | PA |
| 43881 | PA; IC |
| 43882 | IC |
| 43886 | PA |
| 43887 | PA |
| 43888 | PA |
| 43999 | IC |
| 44133 | IC |
| 44135 | PA; IC |
| 44136 | PA; IC |
| 44238 | IC |
| 44799 | IC |
| 44899 | IC |
| 44979 | IC |
| 45499 | IC |
| 45999 | IC |
| 46999 | IC |
| 47135 | PA |
| 47136 | PA |
| 47379 | IC |
| 47399 | IC |
| 47579 | IC |
| 47999 | IC |
| 48554 | PA |
| 48999 | IC |
| 49329 | IC |
| 49659 | IC |
| 49906 | IC |
| 49999 | IC |
| 50549 | IC |
| 50949 | IC |
| 51925 | HI-1 |
| 51999 | IC |
| 53899 | IC |
| 54400 | PA |
| 54401 | PA |
| 54405 | PA |
| 54440 | IC |
| 54699 | IC |
| 55250 | CS-18 or CS-21 |
| 55450 | CS-18 or CS-21 |
| 55559 | IC |
| 55899 | IC |
| 56800 | PA |
| 56805 | IC |
| 57335 | IC |
| 58150 | HI-1 |
| 58152 | HI-1 |
| 58180 | HI-1 |
| 58200 | HI-1 |
| 58210 | HI-1 |
| 58240 | HI-1 |
| 58260 | HI-1 |
| 58262 | HI-1 |
| 58263 | HI-1 |
| 58267 | HI-1 |
| 58270 | HI-1 |
| 58275 | HI-1 |
| 58280 | HI-1 |
| 58285 | HI-1 |
| 58290 | HI-1 |
| 58291 | HI-1 |
| 58292 | HI-1 |
| 58293 | HI-1 |
| 58294 | HI-1 |
| 58541 | HI-1 |
| 58542 | HI-1 |
| 58543 | HI-1 |
| 58544 | HI-1 |
| 58548 | HI-1 |
| 58550 | HI-1 |
| 58552 | HI-1 |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code | and Req. or Limit |
|---|---|
| 58553 | HI-1 |
| 58554 | HI-1 |
| 58565 | CS-18 or CS-21 |
| 58570 | HI-1 |
| 58571 | HI-1 |
| 58572 | HI-1 |
| 58573 | HI-1 |
| 58578 | IC |
| 58579 | IC |
| 58600 | CS-18 or CS-21 |
| 58605 | CS-18 or CS-21 |
| 58611 | CS-18 or CS-21 |
| 58615 | CS-18 or CS-21 |
| 58661 | CS-18 or CS-21 |
| 58670 | CS-18 or CS-21 |
| 58671 | CS-18 or CS-21 |
| 58679 | IC |
| 58951 | HI-1 |
| 58956 | HI-1 |
| 58999 | IC |
| 59135 | HI-1 |
| 59525 | HI-1 |
| 59840 | CPA-2 (first trimester) |
| 59841 | CPA-2 (first trimester) |
| 59850 | CPA-2 (second trimester, third trimester in hospital only) |
| 59851 | CPA-2 (second trimester, third trimester in hospital only) |
| 59852 | CPA-2 (second trimester, third trimester in hospital only) |
| 59855 | CPA-2 |
| 59856 | CPA-2 |
| 59857 | CPA-2 |
| 59898 | IC |
| 59899 | IC |
| 60659 | IC |
| 60699 | IC |
| 64650 | PA |
| 64653 | PA |
| 64999 | IC |
| 65757 | IC |
| 66999 | IC |
| 67299 | IC |
| 67399 | IC |

| Service Code | and Req. or Limit |
|---|---|
| 67599 | IC |
| 67900 | PA |
| 67901 | PA |
| 67902 | PA |
| 67903 | PA |
| 67904 | PA |
| 67906 | PA |
| 67908 | PA |
| 67999 | IC |
| 68399 | IC |
| 68899 | IC |
| 69300 | PA |
| 69399 | IC |
| 69710 | IC |
| 69799 | IC |
| 69930 | PA |
| 69949 | IC |
| 69979 | IC |
| 74261 | PA |
| 74262 | PA |
| 76499 | IC |
| 76999 | IC |
| 77058 | PA |
| 77059 | PA |
| 77299 | IC |
| 77399 | IC |
| 77499 | IC |
| 77799 | IC |
| 78099 | IC |
| 78199 | IC |
| 78299 | IC |
| 78399 | IC |
| 78499 | IC |
| 78599 | IC |
| 78699 | IC |
| 78799 | IC |
| 78999 | IC |
| 79999 | IC |
| 81099 | IC |
| 81479 | IC |
| 84999 | IC |
| 85999 | IC |
| 86152 | IC |
| 86153 | IC |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code | Req. or Limit |
|---|---|
| 86849 | IC |
| 86999 | IC |
| 87999 | IC |
| 88199 | IC |
| 88299 | IC |
| 88384 | IC |
| 88399 | IC |
| 89240 | IC |
| 90288 | IC |
| 90291 | IC |
| 90296 | IC |
| 90378 | PA; IC |
| 90393 | PA; IC |
| 90399 | IC |
| 90476 | IC |
| 90477 | IC |
| 90581 | IC |
| 90632 | Covered for adults ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90636 | IC |
| 90649 | Covered for members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90650 | Covered for female members aged 19 to 26; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90653 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90654 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90661 | IC |
| 90662 | IC |
| 90664 | IC |
| 90666 | IC |
| 90667 | IC |
| 90668 | IC |
| 90670 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90672 | IC; Covered for members > 19 < 49; available free-of-charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90676 | IC |
| 90681 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90690 | IC |
| 90692 | IC |
| 90693 | IC |
| 90696 | IC |
| 90707 | Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90713 | Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90715 | Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90716 | Covered for members ≥ 19; available free of charge through the Massachusetts Immunization |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code | Req. or Limit |
| --- | --- |
| | Program for children under 19 years of age. |
| 90719 | IC |
| 90725 | IC |
| 90727 | IC |
| 90732 | Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90734 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90736 | IC; PA is required for members less than age 50 |
| 90738 | IC |
| 90739 | IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age. |
| 90749 | IC |
| 90867 | IC |
| 90868 | IC |
| 90899 | IC |
| 90935 | For hospitalized member only; not for chronic maintenance |
| 90937 | For hospitalized member only; not for chronic maintenance |
| 90945 | For hospitalized member only; not for chronic maintenance |
| 90947 | For hospitalized member only; not for chronic maintenance |
| 90952 | IC |
| 90953 | IC |
| 91110 | PA |
| 91111 | PA |
| 91299 | IC |
| 92065 | PA |
| 92250 | PA |
| 92310 | PA; includes supply of lenses |
| 92311 | PA; includes supply of lenses |
| 92312 | PA; includes supply of lenses |
| 92313 | PA; includes supply of lenses |
| 92326 | PA |
| 92499 | IC |
| 92506 | PA for ST >35 |
| 92507 | PA for ST >35 |
| 92508 | PA for ST >35 |
| 92526 | PA for ST >35 |
| 92588 | IC |
| 92610 | PA for ST >35 |
| 92700 | IC |
| 92992 | IC |
| 92993 | IC |
| 93229 | IC |
| 93299 | IC |
| 93745 | IC |
| 93799 | IC |
| 93998 | IC |
| 94772 | IC |
| 94774 | IC |
| 94775 | IC |
| 94776 | IC |
| 94777 | IC |
| 94799 | IC |
| 95199 | IC |
| 95803 | IC |
| 95999 | IC |
| 96110 | Developmental screening, with interpretation and report, per standardized instrument form. 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; must be accompanied by modifiers found in Section 605 under Behavioral Health Screening Modifiers to indicate whether a behavioral health need was identified. |
| 96379 | IC |

603 Codes That Have Special Requirements or Limitations (cont.)

| Service Code and Req. or Limit | |
|---|---|
| 96549 | IC |
| 96999 | IC |
| 97001 | PA for PT >20 |
| 97002 | PA for PT >20 |
| 97003 | PA for OT >20 |
| 97004 | PA for OT >20 |
| 97010 | PA for PT >20 |
| 97012 | PA for PT >20 |
| 97016 | PA for PT >20 |
| 97018 | PA for PT >20 |
| 97022 | PA for PT >20 |
| 97024 | PA for PT >20 |
| 97026 | PA for PT >20 |
| 97028 | PA for PT >20 |
| 97032 | PA for PT >20 |
| 97033 | PA for PT >20 |
| 97034 | PA for PT >20 |
| 97035 | PA for PT >20 |
| 97036 | PA for PT >20 |
| 97039 | PA for PT >20; IC |
| 97110 | PA for PT >20 |
| 97112 | PA for PT >20 |
| 97113 | PA for PT >20 |
| 97116 | PA for PT >20 |
| 97124 | PA for PT >20 |
| 97139 | PA for PT >20; IC |
| 97140 | PA for PT >20 |
| 97150 | PA for PT >20 |
| 97530 | PA for OT >20 |
| 97532 | PA for OT >20 |
| 97533 | PA for OT >20 |
| 97535 | PA for OT >20 |
| 97542 | PA for OT >20 |
| 97760 | PA for OT >20 |
| 97761 | PA for OT >20 |
| 97762 | PA for OT >20 |
| 97799 | IC |
| 98925 | PA for OMT >20 |
| 98926 | PA for OMT >20 |
| 98927 | PA for OMT >20 |
| 98928 | PA for OMT >20 |
| 98929 | PA for OMT >20 |
| 99000 | Centrifuging required |
| 99050 | Urgent care only |
| 99051 | Urgent care only |
| 99070 | IC; excluding family planning supplies, such as trays, used in the collection of specimens |
| 99174 | PA |
| 99195 | For hematologic disorders only |
| 99199 | IC |
| 99499 | IC |
| 99600 | IC |

604 Payable HCPCS Level II Service Codes

This section lists Level II HCPCS codes that are payable under MassHealth. Refer to the Centers for Medicare & Medicaid Services website at www.cms.gov/medicare/hcpcs for more detailed descriptions when billing for Level II HCPCS codes provided to MassHealth members.

| Service Code | Service Description |
|---|---|
| A4261 | Cervical cap for contraceptive use (IC) |
| A4266 | Diaphragm for contraceptive use |
| A4267 | Contraceptive supply, condom, male, each |
| A4268 | Contraceptive supply, condom, female, each |
| A4269 | Contraceptive supply, spermicide (e.g., foam, gel), each |
| A4641 | Radiopharmaceutical, diagnostic, not otherwise classified (IC) |
| A4648 | Tissue marker, implantable, any type, each (IC) |
| A9500 | Technetium Tc-99m sestamibi, diagnostic, per study dose (IC) |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
| --- | --- |
| A9502 | Technetium Tc-99m tetrofosmin, diagnostic, per study dose (IC) |
| A9503 | Technetium Tc-99m medronate, diagnostic, per study, up to 30 millicuries (IC) |
| A9505 | Thallium T1-201 thallous chloride, diagnostic, per millicurie (IC) |
| A9512 | Technetium Tc-99m pertechnetate, diagnostic, per millicurie (IC) |
| A9537 | Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries (IC) |
| D1206 | Topical fluoride varnish; therapeutic application for moderate to high caries risk patients (once per three-month period) |
| G0027 | Semen analysis: presence and/or mobility of sperm excluding Huhner |
| G0105 | Colorectal cancer screening; colonoscopy on individual at high risk |
| 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 |
| G0121 | Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk |
| G0202 | Screening mammography, producing direct digital image, bilateral, all views |
| G0204 | Diagnostic mammography, producing direct digital image, bilateral, all views |
| G0206 | Diagnostic mammography, producing direct digital image, unilateral, all views |
| 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 |
| G0431 | Drug screen qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter |
| G0434 | Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter |
| J0129 | Injection, abatacept, 10 mg (PA) |
| J0131 | Injection, acetaminophen, 10 mg (IC) |
| J0135 | Injection, adalimumab, 20 mg (PA) |
| J0171 | Injection, Adrenalin, epinephrine, 0.1 mg (IC) |
| J0178 | Injection, aflibercept, 1 mg (PA) |
| J0215 | Injection, alefacept, 0.5 mg (PA) |
| J0221 | Injection, alglucosidase alfa (Lumizyme), 10 mg (PA) (IC) |
| J0256 | Injection, alpha 1-proteinase inhibitor–human, 10 mg |
| J0257 | Injection, alpha 1 proteinase inhibitor (human) (GLASSIA), 10 mg (IC) |
| J0290 | Injection, ampicillin sodium, 500 mg |
| J0295 | Injection, ampicillin sodium/sulbactam sodium, per 1.5 g |
| J0348 | Injection, anidulafungin, 1 mg |
| J0456 | Injection, azithromycin, 500 mg |
| J0461 | Injection, atropine sulfate, 0.01 mg |
| J0475 | Injection, baclofen, 10 mg |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
|---|---|
| J0476 | Injection, baclofen, 50 mcg for intrathecal trial |
| J0485 | Injection, belatacept, 1 mg (PA) |
| J0490 | Injection, belimumab, 10 mg (PA) (IC) |
| J0558 | Injection, penicillin G benzathine and penicillin G procaine, 100,000 units (IC) |
| J0561 | Injection, penicillin G benzathine, 100,000 units (IC) |
| J0585 | Injection onabotulinumtoxinA, 1 unit (PA) |
| J0586 | Injection, abobotulinumtoxinA, 5 units (PA) |
| J0587 | Injection rimabotulinumtoxinB, 100 units (PA) |
| J0588 | Injection, incobotulinumtoxinA, 1 unit (PA) (IC) |
| J0592 | Injection, buprenorphine HCl, 0.1 mg |
| J0597 | Injection, C-1 esterase inhibitor (human), Berinert, 10 units (IC) |
| J0598 | Injection, C1 esterase inhibitor (human), Cinryze, 10 units (PA) |
| J0638 | Injection, canakinumab, 1 mg (PA) (IC) |
| J0640 | Injection, leucovorin calcium, per 50 mg |
| J0690 | Injection, cefazolin sodium, 500 mg |
| J0694 | Injection, cefoxitin sodium, 1 g |
| J0696 | Injection, ceftriaxone sodium, per 250 mg |
| J0697 | Injection, sterile cefuroxime sodium, per 750 mg |
| J0702 | Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg |
| J0715 | Injection, ceftizoxime sodium, per 500 mg (PA) (IC) |
| J0716 | Injection, centruroides immune f(ab)2, up to 120 milligrams (IC) |
| J0718 | Injection, certolizumab pegol, 1 mg (PA) |
| J0775 | Injection, collagenase, clostridium histolyticum, 0.01 mg (PA) (IC) |
| J0780 | Injection, prochlorperazine, up to 10 mg |
| J0833 | Injection, cosyntropin, not otherwise specified, 0.25 mg |
| J0834 | Injection, cosyntropin (Cortrosyn), 0.25 mg |
| J0840 | Injection, crotalidae polyvalent immune fab (ovine), up to 1 g (IC) |
| J0881 | Injection, darbepoetin alfa, 1 mcg (non-ESRD use) (PA) |
| J0882 | Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis) (PA) |
| J0885 | Injection, epoetin alfa (for non-ESRD use), 1000 units (PA) |
| J0886 | Injection, epoetin alfa, 1000 units (for ESRD on dialysis) (PA) |
| J0890 | Injection, peginesatide, 0. 1 mg (for esrd on dialysis) (PA) |
| J0897 | Injection, denosumab, 1 mg (PA) (IC) |
| J0900 | Injection, testosterone enanthate and estradiol valerate, up to 1 cc (IC) |
| J1020 | Injection, methylprednisolone acetate, 20 mg |
| J1030 | Injection, methylprednisolone acetate, 40 mg |
| J1040 | Injection, methylprednisolone acetate, 80 mg |
| J1050 | Injection, medroxyprogesterone acetate, 1 mg |
| J1060 | Injection, testerone cypionate and estradiol cypionate, up to 1 ml |
| J1070 | Injection, testosterone cypionate, up to 100 mg |
| J1080 | Injection, testosterone cypionate, 1 cc, 200 mg |
| J1094 | Injection, dexamethasone acetate, 1 mg |
| J1100 | Injection, dexamethosone sodium phosphate, 1 mg |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
| --- | --- |
| J1160 | Injection, digoxin, up to 0.5 mg |
| J1170 | Injection, hydromorphone, up to 4 mg |
| J1200 | Injection, diphenhydramine HCl, up to 50 mg |
| J1260 | Injection, dolasetron mesylate, 10 mg |
| J1290 | Injection, ecallantide, 1 mg (IC) |
| J1300 | Injection, eculizumab, 10 mg (IC) |
| J1320 | Injection, amitriptyline HCl, up to 20 mg (IC) |
| J1438 | Injection, etanercept, 25 mg (PA) |
| J1440 | Injection, filgrastim (G-CSF), 300 mcg |
| J1441 | Injection, filgrastim (G-CSF), 480 mcg |
| J1460 | Injection, gamma globulin, intramuscular, 1 cc |
| J1557 | Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg (PA) (IC) |
| J1559 | Injection, immune globulin (Hizentra), 100 mg (PA) (IC) |
| J1561 | Injection, immune globulin, (Gamunex), intravenous, nonlyophilized (e.g., liquid), 500 mg |
| J1562 | Injection, immune globulin, (Vivaglobin), 100 mg (PA) |
| J1566 | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg (PA) |
| J1569 | Injection, immune globulin (Gammagard liquid), intravenous, nonlyophilized (e.g., liquid), 500 mg (PA) |
| J1571 | Injection, hepatitis B immune globulin (Hepagam B), intramuscular, 0.5 ml |
| J1580 | Injection, garamycin, gentamicin, up to 80 mg |
| J1599 | Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg (PA) (IC) |
| J1626 | Injection, granisetron HCl, 100 mcg |
| J1630 | Injection, haloperidol, up to 5 mg |
| J1650 | Injection, enoxaparin sodium, 10 mg |
| J1655 | Injection, tinzaparin sodium, 1000 IU |
| J1670 | Injection, tetanus immune globulin, human, up to 250 units |
| J1710 | Injection, hydrocortisone sodium phosphate, up to 50 mg (IC) |
| J1720 | Injection, hydrocortisone sodium succinate, up to 100 mg |
| J1725 | Injection, hydroxyprogesterone caproate, 1 mg (PA) (IC) |
| J1740 | Injection, ibandronate sodium, 1 mg (PA) |
| J1743 | Injection, idursulfase, 1 mg (IC) |
| J1744 | Injection, icatibant, 1 mg (PA) (IC) |
| J1745 | Injection, infliximab, 10 mg (PA) |
| J1750 | Injection, iron dextran, 50 mg |
| J1786 | Injection, imiglucerase, 10 units (PA) (IC) |
| J1790 | Injection, droperidol, up to 5 mg |
| J1800 | Injection, propranolol HCl, up to 1 mg |
| J1826 | Injection, interferon beta-1a, 30 mcg (IC) |
| J1885 | Injection, ketorolac, tromethamine, per 15 mg |
| J1890 | Injection, cephalothin sodium, up to 1 g (IC) |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
|---|---|
| J1950 | Injection, leuprolide acetate (for depot suspension), per 3.75 mg (PA) |
| J1956 | Injection, levofloxacin, 250 mg |
| J1990 | Injection, chlordiazepoxide HCl, up to 100 mg |
| J2060 | Injection, lorazepam, 2 mg |
| J2150 | Injection, mannitol, 25% in 50 ml |
| J2175 | Injection, meperidine HCl, per 100 mg |
| J2212 | Injection, methylnaltrexone, 0. 1 mg (IC) (PA) |
| J2248 | Injection, micafungin sodium, 1 mg |
| J2250 | Injection, midazolam HCl, per 1 mg |
| J2265 | Injection, minocycline HCl, 1 mg (IC) |
| J2270 | Injection, morphine sulfate, up to 10 mg |
| J2271 | Injection, morphine sulfate, 100 mg |
| J2275 | Injection, morphine sulfate (preservative-free sterile solution), per 10 mg |
| J2300 | Injection, nalbuphine HCl, per 10 mg |
| J2310 | Injection, naloxone HCl, per 1 mg |
| J2315 | Injection, naltrexone, depot form, 1 mg (PA) |
| J2323 | Injection, natalizumab, 1 mg |
| J2355 | Injection, oprelvekin, 5 mg (PA) |
| J2357 | Injection, omalizumab, 5 mg (PA) |
| J2358 | Injection, olanzapine, long-acting, 1 mg (PA) (IC) |
| J2405 | Injection, ondansetron HCl, per 1 mg |
| J2426 | Injection, paliperidone palmitate extended release, 1 mg (PA) (IC) |
| J2430 | Injection, pamidronate disodium, per 30 mg |
| J2440 | Injection, papaverine HC1, up to 60 mg |
| J2469 | Injection, palonosetron HCl, 25 mcg |
| J2503 | Injection, pegaptanib sodium, 0.3 mg |
| J2505 | Injection, pegfilgrastim, 6 mg |
| J2507 | Injection, pegloticase, 1 mg (PA) (IC) |
| J2510 | Injection, penicillin G procaine, aqueous, up to 600,000 units |
| J2515 | Injection, pentobarbital sodium, per 50 mg |
| J2550 | Injection, promethazine HCl, up to 50 mg |
| J2560 | Injection, phenobarbital sodium, up to 120 mg |
| J2562 | Injection, plerixafor, 1 mg |
| J2675 | Injection, progesterone, per 50 mg |
| J2680 | Injection, fluphenazine decanoate, up to 25 mg |
| J2760 | Injection, phentolamine mesylate, up to 5 mg |
| J2778 | Injection, ranibizumab, 0.1 mg |
| J2785 | Injection, regadenoson, 0.1 mg |
| J2788 | Injection, Rho D immune globulin, human, minidose, 50 mcg |
| J2790 | Injection, Rho D immune globulin, human, full dose, 300 mcg |
| J2792 | Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU |
| J2793 | Injection, rilonacept, 1 mg (PA) |
| J2794 | Injection, risperidone, long acting, 0.5 mg |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
| --- | --- |
| J2796 | Injection, romiplostim, 10 mcg (PA) |
| J2820 | Injection, sargramostim (GM-CSF), 50 mcg |
| J2910 | Injection, aurothioglucose, up to 50 mg (IC) |
| J2916 | Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg |
| J2920 | Injection, methylprednisolone sodium succinate, up to 40 mg |
| J2930 | Injection, methylprednisolone sodium succinate, up to 125 mg |
| J2940 | Injection, somatrem, 1 mg (PA) (IC) |
| J2941 | Injection, somatropin, 1 mg (PA) |
| J3010 | Injection, fentanyl citrate, 0.1 mg |
| J3030 | Injection, sumatriptan succinate, 6 mg |
| J3095 | Injection, telavancin, 10 mg (PA) (IC) |
| J3110 | Injection, teriparatide, 10 mcg (PA) (IC) |
| J3120 | Injection, testosterone enanthate, up to 100 mg |
| J3130 | Injection, testosterone enanthate, up to 200 mg |
| J3230 | Injection, chlorpromazine HCl, up to 50 mg |
| J3240 | Injection, thyrotropin alpha, 0.9 mg. provided in 1.1 mg vial |
| J3243 | Injection, tigecycline, 1 mg |
| J3250 | Injection, trimethobenzamide HCl, up to 200 mg |
| J3262 | Injection, tocilizumab, 1 mg (PA) (IC) |
| J3301 | Injection, triamcinolone acetonide, not otherwise specified, 10 mg |
| J3302 | Injection, triamcinolone diacetate, per 5 mg |
| J3303 | Injection, triamcinolone hexacetonide, per 5 mg |
| J3357 | Injection, ustekinumab, 1 mg (PA) (IC) |
| J3360 | Injection, diazepam, up to 5 mg |
| J3385 | Injection, velaglucerase alfa, 100 units (PA) (IC) |
| J3396 | Injection, verteporfin, 0.1 mg |
| J3410 | Injection, hydroxyzine HCl, up to 25 mg |
| J3411 | Injection, thiamine HCI, 100 mg |
| J3430 | Injection, phytonadione (vitamin K), per 1 mg |
| J3487 | Injection, zoledronic acid (Zometa), 1 mg |
| J3490 | Unclassified drugs (IC) |
| J3490-FP | Unclassified drugs (service provided as part of Medicaid family planning program) (Use for medications and injectables related to family planning services, with the exception of Rho (D) human immune globulin, and contraceptive injectables such as Depo-Provera, items for which MassHealth will pay the provider's costs.) (IC) |
| J3590 | Unclassified biologics (IC) |
| J7030 | Infusion, normal saline solution, 1,000 cc |
| J7060 | 5% dextrose/water (500 ml = 1 unit) |
| J7070 | Infusion, D-5-W, 1,000 cc |
| J7131 | Hypertonic saline solution, 1 ml (IC) |
| J7178 | Injection, human fibrinogen concentrate, 1 mg (IC) |
| J7302 | Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (IC) |
| J7303 | Contraceptive supply, hormone containing vaginal ring, each (IC) |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
|---|---|
| J7304 | Contraceptive supply, hormone containing patch, each (IC) |
| J7307 | Etonogestrel (contraceptive) implant system, including implant and supplies (IC) |
| J7309 | Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g (IC) |
| J7312 | Injection, dexamethasone, intravitreal implant, 0.1 mg (IC) |
| J7321 | Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose (PA) |
| J7323 | Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose (PA) |
| J7324 | Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose (PA) |
| J7325 | Hyaluronan or derivative, Synvisc or Synvisc-One for intra-articular injection, 1 mg (PA) |
| J7326 | Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose (PA) (IC) |
| J7335 | Capsaicin 8% patch, per 10 sq cm (PA) (IC) |
| J7527 | Everolimus, oral, 0. 25 mg |
| J7599 | Immunosuppressive drug, not otherwise specidfied (IC) |
| J7608 | Acetylcysteine, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit-dose form, per g |
| J7614 | Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg (PA) |
| J7620 | Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, noncompounded, administered through DME |
| J7626 | Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 0.5 mg |
| J7633 | Budesonide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, per 0.25 mg (IC) |
| J7639 | Dornase alpha, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg |
| J7644 | Ipratropium bromide, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per mg |
| J7665 | Mannitol, administered through an inhaler, 5 mg (IC) |
| J7669 | Metaproterenol sulfate, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, per 10 mg |
| J7676 | Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg (IC) |
| J7682 | Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg |
| J7686 | Treprostinil, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, 1.74 mg (PA) (IC) |
| J7699 | NOC drugs, inhalation solution administered through DME (IC) |
| J7799 | NOC drugs, other than inhalation drugs, administered through DME (IC) |
| J8562 | Fludarabine phosphate, oral, 10 mg (IC) |
| J9000 | Injection, doxorubicin HCl, 10 mg |
| J9002 | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg |
| J9019 | Injection, asparaginase (erwinaze), 1,000 iu (PA) |
| J9025 | Injection, azacitidine, 1 mg |
| J9031 | BCG (intravesical), per instillation |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
|---|---|
| J9035 | Injection, bevacizumab, 10 mg |
| J9040 | Injection bleomycin sulfate, 15 units |
| J9041 | Injection, bortezomib, 0.1 mg |
| J9042 | Injection, brentuximab vedotin, 1 mg (PA) |
| J9043 | Injection, cabazitaxel, 1 mg (PA) (IC) |
| J9045 | Injection, carboplatin, 50 mg |
| J9055 | Injection, cetuximab, 10 mg |
| J9060 | Injection, cisplatin, powder or solution, 10 mg |
| J9070 | Injection, cyclophosphamide, 100 mg |
| J9130 | Dacarbazine, 100 mg |
| J9155 | Injection, degarelix, 1 mg (PA) |
| J9171 | Injection, docetaxel, 1 mg |
| J9178 | Injection, epirubicin HCl, 2 mg |
| J9179 | Injection, eribulin mesylate, 0.1 mg (PA) (IC) |
| J9181 | Injection, etoposide, 10 mg |
| J9190 | Injection, fluorouracil, 500 mg |
| J9201 | Injection, gemcitabine HC1, 200 mg |
| J9202 | Goserelin acetate implant, per 3.6 mg (PA) |
| J9206 | Injection, irinotecan, 20 mg |
| J9212 | Injection, interferon alfacon-1, recombinant, 1 mcg |
| J9213 | Injection, interferon, alfa-2a, recombinant, 3 million units |
| J9214 | Injection, interferon, alfa-2b, recombinant, 1 million units |
| J9215 | Injection, interferon alfa-N3 (human leukocyte derived), 250,000 IU (IC) |
| J9216 | Injection, interferon gamma-1-b, 3 million units |
| J9217 | Leuprolide acetate (for depot suspension), 7.5 mg (PA) |
| J9218 | Leuprolide acetate, per 1 mg (PA) |
| J9219 | Leuprolide acetate implant, 65 mg (PA) |
| J9228 | Injection, ipilimumab, 1 mg (IC) |
| J9250 | Methotrexate sodium, 5 mg |
| J9260 | Methotrexate sodium, 50 mg |
| J9261 | Injection, nelarabine, 50 mg (PA) |
| J9263 | Injection, oxaliplatin, 0.5 mg |
| J9264 | Injection, paclitaxel protein-bound particles, 1 mg |
| J9265 | Injection, paclitaxel, 30 mg |
| J9293 | Injection, mitoxantrone HCl, per 5 mg |
| J9300 | Injection, gemtuzumab ozogamicin, 5 mg |
| J9302 | Injection, ofatumumab, 10 mg (PA) (IC) |
| J9305 | Injection, pemetrexed, 10 mg |
| J9307 | Injection, pralatrexate, 1 mg (IC) |
| J9310 | Injection, rituximab, 100 mg (PA) |
| J9315 | Injection, romidepsin, 1 mg (PA) (IC) |
| J9340 | Injection, thiotepa, 15 mg |
| J9351 | Injection, topotecan, 0.1 mg (IC) |

604 Payable HCPCS Level II Service Codes (cont.)

| Service Code | Service Description |
|---|---|
| J9355 | Trastuzumab, 10 mg |
| J9360 | Injection, vinblastine sulfate, 1 mg |
| J9370 | Vincristine sulfate, 1 mg |
| J9390 | Injection vinorelbine tartrate, 10 mg |
| J9395 | Injection, fulvestrant, 25 mg (PA) |
| J9999 | Not otherwise classified, antineoplastic drugs (IC) |
| Q4101 | Apligraf, per sq cm |
| Q4102 | Oasis wound matrix, per sq cm |
| Q4103 | Oasis burn matrix, per sq cm |
| Q4104 | Integra bilayer matrix wound dressing (BMWD), per sq cm |
| Q4106 | Dermagraft, per sq cm |
| Q4107 | GRAFTJACKET, per sq cm |
| Q4108 | Integra matrix, per sq cm |
| Q4110 | PriMatrix, per sq cm |
| S0020 | Injection, bupivicaine HCl, 30 ml |
| S0021 | Injection, cefoperazone sodium, 1 g (IC) |
| S0023 | Injection, cimetidine HCl, 300 mg |
| S0077 | Injection, clindamycin phosphate, 300 mg |
| S0190 I.C. | Mifepristone, Oral, 200MG |
| S0191 I.C. | Misoprostol, Oral, 200MCG |
| S0199 | Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits confirmation of pregnancy by Hcg, Ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs |
| S0302 | Completed early periodic screening diagnosis and treatment (EPSDT) service (or preventative pediatric healthcare screening and diagnosis (PPHSD) service) (List in addition to code for appropriate evaluation and management service.) |
| S2260 | Induced abortion, 17 to 24 weeks, (CPA-2) (second trimester, third trimester in hospital only) |
| S4989 | Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies (IC) |
| S4993 | Contraceptive pills for birth control |
| T1023 | Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter |
| V2600 | Hand held low vision aids and other nonspectacle-mounted aids (PA) (IC) |
| V2610 | Single lens, spectacle mounted low vision aids (PA) (IC) |
| V2615 | Telescopic and other compound lens system, including distance-vision telescopic, near-vision telescopes, and compound microscopic lens system (PA) (IC) |
| V2799 | Vision service, miscellaneous (PA) (IC) |

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth. See Subchapter 5 of the *Physician Manual* for billing instructions related to the use of modifiers.

| Modifier | 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 same day of the procedure or other service |
| 26 | Professional component |
| 50 | Bilateral procedure |
| 51 | Multiple procedures |
| 54 | Surgical care only |
| 57 | Decision for surgery |
| 58 | Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period |
| 59 | Distinct procedural service |
| 62 | Two surgeons |
| 66 | Surgical team |
| 78 | Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period |
| 79 | Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period |
| 80 | Assistant surgeon |
| 82 | Assistant surgeon (when qualified resident surgeon not available) |
| 91 | Repeat clinical diagnostic laboratory test |
| 99 | Multiple modifiers |
| E1 | Upper left, eyelid |
| E2 | Lower left, eyelid |
| E3 | Upper right, eyelid |
| E4 | Lower right eyelid |
| F1 | Left hand, second digit |
| F2 | Left hand, third digit |
| F3 | Left hand, fourth digit |
| F4 | Left hand, fifth digit |
| F5 | Right hand, thumb |
| F6 | Right hand, second digit |
| F7 | Right hand, third digit |
| F8 | Right hand, fourth digit |
| F9 | Right hand, fifth digit |
| FA | Left hand, thumb |
| FP | Service provided as part of family planning program |

605 Modifiers (cont.)

| Modifier | Modifier Description |
|---|---|
| HN | Bachelor's degree level (Use to indicate physician assistant.) (This modifier is to be applied to codes for services billed by a physician that were performed by a physician assistant employed by the physician or group practice.) |
| LC | Left circumflex coronary artery |
| LD | Left anterior descending coronary artery |
| LM | Left main coronary artery |
| LT | Left side (Used to identify procedures performed on the left side of the body.) |
| RB | Replacement of a DME, orthotic, or prosthetic item furnished as part of a repair (This modifier should only be used with 92340, 92341, and 92342 to bill for the dispensing of replacement lenses.) |
| RC | Right coronary artery |
| RI | Ramus intermedius coronary artery |
| RT | Right side (Used to identify procedures performed on the right side of the body.) |
| SA | Nurse practitioner rendering service in collaboration with a physician (This modifier is to be applied to codes for services billed by a physician that were performed by a non-independent nurse practitioner employed by the physician or group practice.) (An independent nurse practitioner billing under his/her own individual provider number should not use this modifier.) |
| SB | Nurse midwife (This modifier is to be applied to codes for services billed by a physician that were performed by a non-independent nurse midwife employed by the physician or group practice.) (An independent nurse midwife billing under his/her own individual provider number should not use this modifier.) |
| SL | State-supplied vaccine (This modifier should only be applied to codes 90460, 90461, 90471, and 90473 to identify administration of vaccines provided at no cost by the Massachusetts Department of Public Health for individuals aged 18 years and under, including those administered under the Vaccine for Children Program (VFC).) |
| T1 | Left foot, second digit |
| T2 | Left foot, third digit |
| T3 | Left foot, fourth digit |
| T4 | Left foot, fifth digit |
| T5 | Right foot, great toe |
| T6 | Right foot, second digit |
| T7 | Right foot, third digit |
| T8 | Right foot, fourth digit |
| T9 | Right foot, fifth digit |
| TA | Left foot, great toe |
| TC | Technical component (The component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedures, excluding the physician's professional component. When the technical component is reported separately the addition of modifier TC to the service code will let the technical component allowable fee contained in 101 CMR 317.04 be paid.) |

605 Modifiers (cont.)

### Modifiers for Tobacco-Cessation Services

The following modifiers are used in combination with Service Code 99407 to report tobacco-cessation counseling. Service Code 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) may also be billed without a modifier to report an individual smoking and tobacco-use cessation counseling visit of at least 30 minutes.

| Modifier | Modifier Description |
|---|---|
| HQ | Group counseling, at least 60-90 minutes in duration, provided by a physician |
| TD | Individual counseling provided by a registered nurse (RN) |
| TF | Individual counseling, intermediate level of care (intake/assessment counseling, at least 45 minutes in duration) provided by a physician |
| U1 | Individual counseling services provided by a tobacco-cessation counselor |
| U2 | Individual intake/assessment counseling, at least 45 minutes in duration, provided by a nurse practitioner, nurse midwife, physician assistant, registered nurse, or a tobacco-cessation counselor, under the supervision of a physician |
| U3 | Group counseling, at least 60-90 minutes in duration, provided by a nurse practitioner, nurse midwife, physician assistant, registered nurse, or a tobacco-cessation counselor, under the supervision of a physician |

### Modifiers for Behavioral Health Screening

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 96110 must be accompanied by one of the modifiers listed below to indicate whether a behavioral health need was identified. “Behavioral health need identified” means the provider administering the screening tool, in his or her professional judgment, identified a child with a potential behavioral health services need.

| Modifier | Modifier Description |
|---|---|
| U1 | Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual with **no** behavioral health need identified when administered by a physician, independent nurse midwife or independent nurse practitioner. |
| U2 | Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual and a behavioral health need was identified when administered by a physician, independent nurse midwife or independent nurse practitioner. |
| U3 | Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual with **no** behavioral health need identified when administered by a nurse midwife employed by a physician. |
| U4 | Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual and a behavioral health need was identified when administered by a nurse midwife employed by a physician. |

605 Modifiers (cont.)

U5 Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual with **no** behavioral health need identified when administered by a nurse practitioner employed by a physician.

U6 Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual and a behavioral health need was identified when administered by a nurse practitioner employed by a physician.

U7 Completed behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual with **no** behavioral health need identified when administered by a physician assistant employed by a physician.

U8 Completed a behavioral health screening using a standardized behavioral health screening tool selected from the approved menu of tools found in Appendix W of your provider manual and a behavioral health need was identified when administered by a physician assistant employed by a physician.

**Modifier for Child and Adolescent Needs and Strengths (CANS)**

| Modifier | Modifier Description |
| --- | --- |
| HA | Service Code 90791 must be accompanied by this modifier to indicate that the Child and Adolescent Needs and Strengths (CANS) is included in the psychiatric diagnostic interview examination. This modifier may be billed only by psychiatrists. |

**Modifiers for Provider Preventable Conditions That Are National Coverage Determinations**

| Modifier | 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.

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