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

MassHealth
Transmittal Letter PHY-142
January 2015

TO: Physicians Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Physician Manual* (Updated Gender Dysphoria and Sterilization Policies)

This letter transmits revisions to the Physician (PHY) regulations as they pertain to treatment for gender dysphoria and sterilization services. This letter also transmits related updates to Subchapter 6 of the *Physician Manual*. A subsequent transmittal letter will be issued to address regulatory changes regarding abortion services.

Gender Dysphoria Policy

This letter transmits revisions to the physician regulations to allow coverage of treatment of gender dysphoria, including gender reassignment surgeries and hormone therapies.

Gender reassignment surgeries and certain hormone therapies require prior authorization. Providers should review the Guidelines for Medical Necessity Determination for Gender Reassignment Surgery, available at www.mass.gov/masshealth/guidelines, and the MassHealth Drug List, available at https://masshealthdruglist.ehs.state.ma.us/MHDL, for more information on prior authorization requirements.

Sterilization Provisions

This letter also transmits revisions to the sterilization provisions in the physician regulations. MassHealth has clarified in its regulations that a provider does not need to submit a copy of the MassHealth Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the updated regulations provide that the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim:

(A) the medical procedure, treatment, or operation was unilateral and did not result in sterilization;

(B) the medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes;

(C) the medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(D) the medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. The physician must also include the nature and date of the life-threatening emergency.

In addition, under the circumstances referenced in (A) and (C), above, the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

These changes continue to conform to federal standards. Please see 130 CMR 433.456 through 433.458, and relevant definitions, for more information and the sterilization provisions.

Related Updates to Subchapter 6 of the *Physician Manual*

This letter also transmits a revised Subchapter 6 of the *Physician Manual*, reflecting updates, as necessary, related to the gender dysphoria and sterilization-related regulatory changes referenced above.

The gender dysphoria-related updates to Subchapter 6 include revisions to the relevant service codes in Section 603, "Codes That Have Special Requirements or Limitations." Service codes for which prior authorization is required for gender dysphoria-related services are identified by "PA (for Gender Dysphoria-Related Services Only)." Note that two such service codes, 55899 and 58999, should be used for gender dysphoria-related requests for the following procedures, pending the release of procedures-specific service codes: 55899 should be used for clitoroplasty, labiaplasty, and vaginoplasty, and 58999 should be used for metoidioplasty and phalloplasty.

The sterilization-related updates to Subchapter 6 include revisions to the relevant legend entries in Section 603, "Codes That Have Special Requirements or Limitations." Service codes always requiring the Consent for Sterilization form will continue to be identified by "CS-18 or CS-21." Service codes for which the Consent for Sterilization form must be submitted, unless the signed attachment referenced above in the "Sterilization Provisions" section is submitted with the claim, will be identified by "CS-18* or CS-21*." Updates were also made as necessary to relevant service codes in Section 603 to reflect the updated legend.

Effective Date

These regulatory amendments and Subchapter 6 updates are effective for dates of service on or after January 2, 2015.

MassHealth Website

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

Questions

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

NEW MATERIAL

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

Physician Manual

Pages iv-a, iv-b, vi, 4-1 through 4-10, 4-37, 4-38, 4-41, 4-42, 4-45 through 4-50, and 6-1 through 6-26

OBSOLETE MATERIAL

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

Physician Manual

Pages iv-a, 4-1, 4-2, 4-7, 4-8, 4-37, 4-38, 4-41, 4-42, 4-45, and 4-46 — transmitted by Transmittal Letter PHY-140

Page vi — transmitted by Transmittal Letter PHY-139

Pages 4-3 and 4-4 — transmitted by Transmittal Letter PHY-122

Pages 4-5 and 4-6 — transmitted by Transmittal Letter PHY-124

Pages 4-9 and 4-10 — transmitted by Transmittal Letter PHY-111

Pages 4-47 through 4-50 — transmitted by Transmittal Letter PHY-109

Pages 6-1 through 6-24 — transmitted by Transmittal Letter PHY-141

4. Program Regulations (cont.)

4. Program Regulations (cont.)

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 disease or physical 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.

Hospital Visit – a bedside visit by a physician to a hospitalized member, except for routine preoperative and postoperative care.

Hysterectomy – a medical procedure or operation for the purpose of removing the uterus.

Independent Diagnostic Testing Facility (IDTF) – a Medicare-certified diagnostic imaging center, freestanding MRI center, portable X-ray provider, sleep center, or mammography van in a fixed location or mobile entity independent of a hospital or physician's office, that performs diagnostic tests and meets the requirements of 130 CMR 431.000: *Independent Diagnostic Testing Facility*.

Individual Psychotherapy – private therapeutic services provided to a member to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual – an individual who is

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

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

Intensive Care Services – the services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

Maintenance Program – repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment and skill of a licensed physician or licensed therapist for safety and effectiveness.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

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

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Non-Drug Product List – a section of the MassHealth Drug List comprised of those products not classified as drugs (i.e., blood testing supplies) that are payable by the MassHealth agency through the Pharmacy Program. Payment for these items is in accordance with rates published in Executive Office of Health and Human Services (EOHHS) 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.

Over-the-Counter Drug – any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs. The MassHealth agency requires a prescription for both prescription drugs and over-the-counter drugs (see 130 CMR 433.441(A)).

Not Otherwise Classified – a term used for service codes that should be used when no other service code is appropriate for the service provided.

Occupational Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Oxygen – gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

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

Pharmacy Online Processing System (POPS) – the online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Physical Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Prescription Drug – any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

Prolonged Detention – constant attendance to a member in critical condition by the attending physician.

Reconstructive Surgery – a surgical procedure performed to correct, repair, or ameliorate the physical effects of disease or physical defect (for example, correction of cleft palate), or traumatic injury.

Referral – the transfer of the total or specific care of a member from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

Respiratory Therapy Equipment – a product that

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;
(2) is of proven quality and dependability; and
(3) conforms to all applicable federal and state product standards.

Routine Study – a set of X rays of an extremity that includes two or more views taken at one sitting.

Separate Procedure – a procedure that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but commands a separate fee when performed as a separate entity not immediately related to other services.

Speech/Language Therapy – therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

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

Therapeutic Radiology Service – a radiology service used to treat an injury or illness.

Therapy Visit – a personal contact provided as an office visit or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office or outpatient visit is considered a therapy visit.

Trimester – one of three three-month terms in a normal pregnancy. If the pregnancy has existed for less than 12 weeks, the pregnancy is in its first trimester. If the pregnancy has existed for 12 or more weeks but less than 24 weeks, the pregnancy is in its second trimester. If the pregnancy has existed for 24 or more weeks, the pregnancy is in its third trimester.

Unit-Dose Distribution System – a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

433.402: Eligible Members

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

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

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

433.403: Provider Eligibility

(A) Participating Providers.

(1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to members by physicians participating in MassHealth as of the date of service.

(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the member. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the member, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and present in the operating room during the major portion of an operation.

(B) In State. An in-state physician is a physician who is licensed by the Massachusetts Board of Registration in Medicine.

(C) Out of State. An out-of-state physician must be licensed to practice in his or her state. The MassHealth agency pays an out-of-state physician for providing covered services to a MassHealth member only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a member who is authorized to reside out of state by the Massachusetts Department of Children and Families.

(3) The physician practices outside a 50-mile radius of the Massachusetts border and provides emergency services to a member.

(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.

(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.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies;
(5) any complications or other circumstances that the MassHealth agency deems relevant;
(6) the policies, procedures, and practices of other third-party insurers;
(7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000: *Pharmacy*; and
(8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

433.407: Service Limitations: Professional and Technical Components of Services and Procedures

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

(1) Mobile Site – any site other than the physician's office, but not including community health centers, hospital outpatient departments, or hospital-licensed health centers.
(2) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.
(3) 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 procedure, excluding the physician's professional component.

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301: *Claims*. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office when the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component.

433.408: Prior Authorization

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The MassHealth agency does not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the MassHealth agency before providing the service.

(2) A prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health insurance payment.

(B) Requesting Prior Authorization. All prior-authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery and gender-reassignment surgery;

(2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain psychiatry services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the MassHealth behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124: *Behavioral Health Services*.

pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with Executive Office of Health and Human Services (EOHHS) 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 EOHHS 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 Executive Office of Health and Human Services (EOHHS) 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 gender-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy.

(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

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;
(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 disease or physical 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 18th 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.

(C) 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 a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of sterilization 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 have a sterilization will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for sterilization services as well as for all other medical services covered by MassHealth.

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 433.456(A) are met.

(D) Locations in Which Sterilizations May Be Performed.

(1) Male sterilization must be performed by a licensed physician in a physician's office, hospital, or sterilization clinic.

(2) Female sterilization must be performed by a licensed physician in a hospital, freestanding ambulatory surgery center, or sterilization clinic.

(3) A hospital, freestanding ambulatory surgery center, or sterilization clinic in which a sterilization is performed must be licensed in compliance with Massachusetts Department of Public Health regulations at 105 CMR 130.000: *Hospital Licensure* or 140.000: *Licensure of Clinics*, as applicable.

433.457: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 433.457(A) and (B), and such consent is documented as specified in 130 CMR 433.458.

(A) Informed Consent Requirements.

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

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

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

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

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

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

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

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 433.457(B)(1).

(2) The person who obtains consent must also
(a) offer to answer any questions the member may have about the sterilization procedure;
(b) give the member a copy of the consent form;
(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 433.457(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;
(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and
(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.
(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 433.457. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is
(a) in labor or childbirth;
(b) seeking to obtain or obtaining an abortion; or
(c) under the influence of alcohol or other substances that affect the individual's state of awareness.
(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 433.457(A)(1).

433.458: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth agency's Consent for Sterilization form in accordance with the following requirements.

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

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

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

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

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

(D) Provider Billing and Required Submissions.

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

(2) A provider does not need to submit a Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation may also be used to bill for a sterilization, the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim.

(a) The medical procedure, treatment, or operation was a unilateral procedure and did not result in sterilization.

(b) The medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes.

(c) The medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(d) The medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. Include the nature and date of the life-threatening emergency.

(3) In the circumstances set forth in 130 CMR 433.458(D)(2)(a) and (c), the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

(4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 433.458(D)(2) (for example, the physician and the hospital), each provider must submit a copy of the signed attachment along with the claim.

433.459: Hysterectomy Services

(A) Nonpayable Services. The MassHealth agency does not pay for a hysterectomy provided to a member under the following conditions.

(1) The hysterectomy was performed solely for the purpose of sterilizing the member.

(2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

(B) Hysterectomy Information Form. The MassHealth agency pays for a hysterectomy only when the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified below.

(1) Prior Acknowledgment. Except under the circumstances specified below, the member and her representative, if any, must be informed orally and in writing before the hysterectomy operation that the hysterectomy will make her permanently incapable of reproducing. (Delivery in hand of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.) Section (B) of the Hysterectomy Information (HI-1) form must be signed and dated by the member or her representative before the operation is performed, as acknowledgment of receipt of this information. Whenever any surgery that includes the possibility of a hysterectomy is scheduled, the member must be informed of the consequences of a hysterectomy, and must sign and date section (B) of the Hysterectomy Information (HI-1) form before surgery.

(2) Prior Sterility. If the member is sterile prior to the hysterectomy operation, the physician who performs the operation must so certify, describe the cause of sterility, and sign and date section (C)(1) of the Hysterectomy Information (HI-1) form.

(3) Emergency Surgery. If the hysterectomy is performed in an emergency, under circumstances that immediately threaten the member's life, and if the physician determines that obtaining the member's prior acknowledgment is not possible, the physician who performs the hysterectomy must so certify, describe the nature of the emergency, and sign and date section (C)(2) of the Hysterectomy Information (HI-1) form.

(4) Retroactive Eligibility. If the hysterectomy was performed during the period of a member's retroactive eligibility, the physician who performed the hysterectomy must certify that one of the following circumstances existed at the time of the operation:

(a) the woman was informed before the operation that the hysterectomy would make her sterile (the physician must sign and date section (D)(1) of the HI-1 form);

(b) the woman was sterile before the hysterectomy was performed (the physician must sign, date, and describe the cause of sterility in section (D)(2) of the HI-1 form); or

(c) the hysterectomy was performed in an emergency that immediately threatened the woman's life and the physician determined that it was not possible to obtain her prior acknowledgment (the physician must sign, date, and describe the nature of the emergency in section (D)(3) of the HI-1 form).

(C) Submission of the Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the MassHealth agency for hysterectomy services. When more than one provider is billing the MassHealth agency for the same hysterectomy, each provider must submit a copy of the completed HI-1 form.

(130 CMR 433.460 through 433.465 Reserved)

601 Introduction

MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology (CPT) 2014* 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: *Administrative and Billing Regulations*, **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	15824	21121	33940	41870
11922	15825	21122	33944	41872
11950	15826	21123	36415	43206
11951	15828	21245	36416	43252
11952	15829	21246	36468	43752
11954	15847	21248	36469	43842
15775	15876	21249	36591	43843
15776	15877	22526	36592	43845
15780	15878	22527	36598	44132
15781	15879	22841	38204	44705
15782	17340	22856	38207	44715
15783	17360	22861	38208	47133
15786	17380	22864	38209	47143
15787	19355	32491	38210	47144
15788	19396	32850	38211	47145
15789	20930	32855	38212	48160
15792	20936	32856	38213	48550
15793	20985	33930	38214	48551
15819	21120	33933	38215	50300

602 Nonpayable CPT Codes (cont.)

50323	76497	81209	81290	81382
50325	76498	81210	81291	81383
54900	77336	81211	81292	81400
54901	77370	81212	81293	81401
55200	77371	81213	81294	81402
55300	77372	81214	81295	81403
55400	77373	81215	81296	81404
55870	77401	81216	81297	81405
55970	77402	81217	81298	81406
55980	77403	81220	81299	81407
58321	77404	81221	81300	81408
58322	77406	81222	81301	81500
58323	77407	81223	81302	81503
58345	77408	81224	81303	81506
58350	77409	81225	81304	81508
58750	77411	81226	81310	81509
58752	77412	81227	81315	81510
58760	77413	81228	81316	81511
58970	77414	81229	81317	81512
58974	77416	81235	81318	81599
58976	77417	81240	81319	82075
59070	77418	81241	81321	82962
59072	77422	81242	81322	83987
59412	77423	81243	81323	84061
59897	77424	81244	81324	84145
61630	77425	81245	81325	84431
61635	77520	81250	81326	84830
61640	77522	81251	81330	86079
61641	77523	81252	81331	86305
61642	77525	81253	81332	86890
62287	77790	81254	81340	86891
63043	78267	81255	81341	86910
63044	78268	81256	81342	86911
65760	78351	81257	81350	86927
65765	80100	81260	81355	86930
65767	80101	81261	81370	86931
65771	80104	81262	81371	86932
69090	80500	81263	81372	86945
71552	80502	81264	81373	86950
72159	81200	81265	81374	86960
72198	81201	81266	81375	86965
73225	81202	81267	81376	86985
74263	81203	81270	81377	87150
75571	81205	81275	81378	87153
76140	81206	81280	81379	87493
76390	81207	81281	81380	87900
76496	81808	81282	81381	87901

602 Nonpayable CPT Codes (cont.)

87903	89342	90885	94644	97546
87904	89343	90889	94645	97755
88000	89344	90901	95012	98940
88005	89346	90911	95052	98941
88007	89352	90940	95120	98942
88012	89353	90989	95125	98943
88014	89354	90993	95130	98960
88016	89356	90997	95131	98961
88020	89398	90999	95132	98962
88025	90281	91112	95133	98966
88027	90283	91132	95134	98967
88028	90284	91133	95824	98968
88029	90287	92314	95965	98969
88036	90384	92315	95966	99001
88037	90386	92316	95967	99002
88040	90389	92317	95992	99024
88045	90396	92325	96000	99026
88099	90586	92352	96001	99027
88125	90633	92353	96002	99053
88333	90634	92354	96003	99056
88334	90644	92355	96004	99058
88738	90645	92358	96040	99060
88749	90646	92371	96101	99071
89250	90647	92531	96102	99075
89251	90648	92532	96103	99078
89253	90653	92533	96105	99080
89254	90669	92534	96111	99082
89255	90680	92548	96116	99090
89257	90698	92559	96118	99091
89258	90700	92560	96119	99100
89259	90702	92561	96120	99116
89260	90708	92562	96125	99135
89261	90710	92564	96150	99140
89264	90712	92597	96151	99143
89268	90720	92605	96152	99144
89272	90721	92606	96153	99145
89280	90723	92613	96154	99148
89281	90739	92615	96155	99149
89290	90743	92617	96376	99150
89291	90744	92630	96567	99172
89321	90748	92633	96902	99190
89322	90845	93660	96904	99191
89325	90863	93668	97005	99192
89329	90865	93770	97006	99241
89330	90875	93786	97014	99242
89331	90876	94005	97537	99243
89335	90880	94015	97545	99244

602 Nonpayable CPT Codes (cont.)

99245	99358	99402	99447	99502
99251	99359	99403	99448	99503
99252	99360	99404	99449	99504
99253	99363	99406	99450	99505
99254	99364	99408	99455	99506
99255	99366	99409	99456	99507
99288	99367	99411	99485	99509
99315	99368	99412	99486	99510
99316	99374	99420	99487	99511
99339	99375	99429	99488	99512
99340	99377	99441	99489	99601
99354	99378	99442	99495	99602
99355	99379	99443	99496	99605
99356	99380	99444	99500	99606
99357	99401	99446	99501	99607

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: *Administrative and Billing Regulations*, 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 450.235: *Overpayments* through 450.260: *Monies Owed by Providers* and 130 CMR 433.455 for more information

CS-18 or CS-21: A completed Sterilization Consent Form (CS-18 for members aged

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

18 through 20; CS-21 form for members aged 21 and older) must be submitted. See 130 CMR 433.456 through 433.458 for more information.

CS-18* or CS-21*: A completed Sterilization Consent Form (CS-18 form for members aged 18 through 20; CS-21 for members aged 21 and older) must be submitted, except if the conditions of 130 CMR 433.458(D)(2) and (3) are met. See 130 CMR 433.456 through 433.458 for more information and other submission requirements.

HI-1: A completed Hysterectomy Information Form must be completed. See 130 CMR 450.235: *Overpayments* through 450.260: *Monies Owed by Providers* 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
11970	PA (for Gender Dysphoria-Related Services Only)
11971	PA (for Gender Dysphoria-Related Services Only)
15820	PA
15821	PA
15822	PA
15823	PA
15830	PA
15832	PA
15833	PA
15834	PA
15835	PA

Service Code and Req. or Limit	
15836	PA
15837	PA
15838	PA
15839	PA
15999	IC
17999	IC
19300	PA
19303	PA (for Gender Dysphoria-Related Services Only)
19304	PA (for Gender Dysphoria-Related Services Only)
19316	PA
19318	PA
19324	PA
19325	PA

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
19328	PA	21743	IC
19350	PA	21899	IC
19499	IC	22857	PA
20999	IC	22862	PA
21085	PA	22865	PA
21088	IC	22899	IC
21089	IC	22999	IC
21137	PA	23929	IC
21138	PA	24940	IC
21139	PA	24999	IC
21146	PA	25999	IC
21147	PA	26989	IC
21150	PA	27299	IC
21151	PA	27599	IC
21154	PA	27899	IC
21155	PA	28890	PA
21159	PA	28899	IC
21160	PA	29799	IC
21172	PA	29800	PA
21175	PA	29804	PA
21188	PA	29999	IC
21193	PA	30400	PA
21194	PA	30410	PA
21195	PA	30420	PA
21196	PA	30430	PA
21198	PA	30435	PA
21206	PA	30450	PA
21208	PA	30999	IC
21209	PA	31299	IC
21210	PA	31599	IC
21215	PA	31899	IC
21230	PA	32851	PA
21235	PA	32852	PA
21240	PA	32853	PA
21242	PA	32854	PA
21243	PA	32999	IC
21244	PA	33935	PA
21247	PA	33945	PA
21255	PA	33981	IC
21256	PA	33982	IC
21299	PA; IC	33983	IC
21499	IC	33999	IC
21742	IC	34841	IC

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
34842	IC	43648	IC
34843	IC	43659	IC
34844	IC	43770	PA
34845	IC	43771	PA
34846	IC	43772	PA
34847	IC	43773	PA
34848	IC	43774	PA
36299	IC	43775	PA
36470	PA	43846	PA
36471	PA	43847	PA
37501	IC	43848	PA
37799	IC	43881	PA; IC
38129	IC	43882	IC
38230	PA	43886	PA
38240	PA	43887	PA
38241	PA	43888	PA
38242	PA	43999	IC
38589	IC	44133	IC
38999	IC	44135	PA; IC
39499	IC	44136	PA; IC
39599	IC	44238	IC
40799	IC	44799	IC
40840	PA	44899	IC
40842	PA	44979	IC
40843	PA	45499	IC
40844	PA	45999	IC
40845	PA	46999	IC
40899	IC	47135	PA
41599	IC	47136	PA
41820	PA; IC	47379	IC
41821	IC	47399	IC
41850	IC	47579	IC
41899	IC	47999	IC
42280	PA	48554	PA
42281	PA	48999	IC
42299	IC	49329	IC
42699	IC	49659	IC
42999	IC	49906	IC
43289	IC	49999	IC
43499	IC	50549	IC
43644	PA	50949	IC
43645	PA	51925	HI-1
43647	PA; IC	51999	IC

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
53430	PA (for Gender Dysphoria-Related Services Only)		Dysphoria-Related Services Only)
53899	IC	58200	HI-1
54125	PA (for Gender Dysphoria-Related Services Only)	58210	HI-1
54400	PA	58240	HI-1
54401	PA	58260	HI-1; PA (for Gender Dysphoria-Related Services Only)
54405	PA		
54440	IC	58262	HI-1; PA (for Gender Dysphoria-Related Services Only)
54520	PA (for Gender Dysphoria-Related Services Only)		
54660	PA (for Gender Dysphoria-Related Services Only)	58263	HI-1
		58267	HI-1
54690	PA (for Gender Dysphoria-Related Services Only)	58270	HI-1
		58275	HI-1
54699	IC	58280	HI-1
55175	PA (for Gender Dysphoria-Related Services Only)	58285	HI-1
		58290	HI-1; PA (for Gender Dysphoria-Related Services Only)
55180	PA (for Gender Dysphoria-Related Services Only)		
55250	CS-18 or CS-21	58291	HI-1; PA (for Gender Dysphoria-Related Services Only)
55450	CS-18 or CS-21		
55559	IC		
55899	IC; PA (for Gender Dysphoria-Related Services Only)	58292	HI-1
		58293	HI-1
56620	PA (for Gender Dysphoria-Related Services Only)	58294	HI-1
		58541	HI-1; PA (for Gender Dysphoria-Related Services Only)
56625	PA (for Gender Dysphoria-Related Services Only)		
56800	PA	58542	HI-1; PA (for Gender Dysphoria-Related Services Only)
56805	IC		
57110	PA (for Gender Dysphoria-Related Services Only)	58543	HI-1; PA (for Gender Dysphoria-Related Services Only)
57291	PA (for Gender Dysphoria-Related Services Only)		
57292	PA (for Gender Dysphoria-Related Services Only)	58544	HI-1; PA (for Gender Dysphoria-Related Services Only)
57335	IC		
58150	HI-1; PA (for Gender Dysphoria- Related Services Only)	58548	HI-1
		58550	HI-1; PA (for Gender Dysphoria-Related Services Only)
58152	HI-1		
58180	HI-1; PA (for Gender	58552	HI-1; PA (for Gender

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
	Dysphoria-Related Services Only)	59841	CPA-2 (first trimester)
58553	HI-1; PA (for Gender Dysphoria-Related Services Only)	59850	CPA-2 (second trimester, third trimester in hospital only)
58554	HI-1; PA (for Gender Dysphoria-Related Services Only)	59851	CPA-2 (second trimester, third trimester in hospital only)
58565	CS-18 or CS-21	59852	CPA-2 (second trimester, third trimester in hospital only)
58570	HI-1; PA (for Gender Dysphoria-Related Services Only)	59855	CPA-2
58571	HI-1; PA (for Gender Dysphoria-Related Services Only)	59856	CPA-2
58572	HI-1; PA (for Gender Dysphoria-Related Services Only)	59857	CPA-2
58573	HI-1; PA (for Gender Dysphoria-Related Services Only)	59898	IC
58578	IC	59899	IC
58579	IC	60659	IC
58600	CS-18 or CS-21	60699	IC
58605	CS-18 or CS-21	64650	PA
58611	CS-18 or CS-21	64653	PA
58615	CS-18 or CS-21	64999	IC
58661	CS-18* or CS-21*; PA (for Gender Dysphoria-Related Services Only)	65757	IC
58670	CS-18 or CS-21	66999	IC
58671	CS-18 or CS-21	67299	IC
58679	IC	67399	IC
58720	CS-18* or CS-21*; PA (for Gender Dysphoria-Related Services Only)	67599	IC
58951	HI-1	67900	PA
58956	HI-1	67901	PA
58999	IC; PA (for Gender Dysphoria-Related Services Only)	67902	PA
59135	HI-1	67903	PA
59525	HI-1	67904	PA
59840	CPA-2 (first trimester)	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

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

Service Code and Req. or Limit	
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
86849	IC
86999	IC
87999	IC
88199	IC
88299	IC
88343	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
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.
90673	IC; Covered for members Covered for members ≥ 19; 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

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

Service Code and Req. or Limit	
	the Massachusetts Immunization Program for children under 19 years of age
90686	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children under 19 years of age
90688	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 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
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	IPC
92507	PA for ST >35
92508	PA for ST >35
92521	PA for ST >35
92522	PA for ST >35
92523	PA for ST >35
92524	PA for ST >35
92526	PA for ST >35
92588	IC

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
92610	PA for ST >35	97012	PA for PT >20
92700	IC	97016	PA for PT >20
92992	IC	97018	PA for PT >20
92993	IC	97022	PA for PT >20
93229	IC	97024	PA for PT >20
93299	IC	97026	PA for PT >20
93745	IC	97028	PA for PT >20
93799	IC	97032	PA for PT >20
93998	IC	97033	PA for PT >20
94669	PA	97034	PA for PT >20
94772	IC	97035	PA for PT >20
94774	IC	97036	PA for PT >20
94775	IC	97039	PA for PT >20; IC
94776	IC	97110	PA for PT >20
94777	IC	97112	PA for PT >20
94799	IC	97113	PA for PT >20
95199	IC	97116	PA for PT >20
95803	IC	97124	PA for PT >20
95999	IC	97139	PA for PT >20; 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.	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
		97610	IC
		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
96379	IC	98929	PA for OMT >20
96549	IC	99000	Centrifuging required
96999	IC	99050	Urgent care only
97001	PA for PT >20	99051	Urgent care only
97002	PA for PT >20	99070	IC; excluding family planning supplies, such as trays, used in the collection of specimens
97003	PA for OT >20		
97004	PA for OT >20		
97010	PA for PT >20	99174	PA

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

Service Code and Req. or Limit		Service Code and Req. or Limit	
99195	For hematologic disorders only	99482	IC
99199	IC	99499	IC
99481	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)
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

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
	(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)
J0151	Inj Adenosine Diag 1mg
J0171	Injection, Adrenalin, epinephrine, 0.1 mg (IC)
J0178	Injection, aflibercept, 1 mg
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
J0401	Injection, aripiprazole, extended release, 1 mg (IC)
J0456	Injection, azithromycin, 500 mg
J0461	Injection, atropine sulfate, 0.01 mg
J0475	Injection, baclofen, 10 mg
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

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
J0715	Injection, ceftizoxime sodium, per 500 mg (PA) (IC)
J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams (IC)
J0717	Certolizumab Pegol Inj 1mg (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, testosterone 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
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)
J1442	Injection, Filgrastim G-CSF 1mcg (PA)
J1446	Injection, tbo-filgrastim, 5 micrograms (IC)
J1460	Injection, gamma globulin, intramuscular, 1 cc
J1556	Injection, Imm Glob Bivigam, 500mg
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)

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
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)
J1602	Injection, golimumab, 1 mg, for intravenous use (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)
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

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
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
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
J3060	Injection, Taliglucerace Alfa 10 u (PA)
J3095	Injection, telavancin, 10 mg (PA) (IC)
J3110	Injection, teriparatide, 10 mcg (PA) (IC)

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
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
J3489	Zoledronic Acid 1mg (PA)
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)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg (IC)
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (IC)
J7303	Contraceptive supply, hormone containing vaginal ring, each (IC)
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)
J7316	Injection, Ocriplasmin, 0.125 mg
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)

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
J7335	Capsaicin 8% patch, per 10 sq cm (PA) (IC)
J7508	Tacrolimus Ex Rel oral 0.1mg
J7527	Everolimus, oral, 0. 25 mg
J7599	Immunosuppressive drug, not otherwise specified (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
J9019	Injection, asparaginase (erwinaze), 1,000 IU (PA)
J9025	Injection, azacitidine, 1 mg
J9031	BCG (intravesical), per instillation
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
J9047	Injection, Carfilzomib, 1 mg (PA)
J9055	Injection, cetuximab, 10 mg

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
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)
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg (PA) (IC)
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
J9306	Injection, Pertuzumab, 1 mg (PA)
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)
J9354	Injection, Ado-trastuzumab Emt 1mg (PA)
J9355	Trastuzumab, 10 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg

604 Payable HCPCS Level II Service Codes (cont.)

Service Code	Service Description
J9371	Injection, vincristine sulfate liposome, 1 mg (PA) (IC)
J9390	Injection vinorelbine tartrate, 10 mg
J9395	Injection, fulvestrant, 25 mg (PA)
J9400	Injection, ziv-aflibercept, 1mg (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.)

Modifier Modifier Description

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.

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.

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.

605 Modifiers (cont.)

Modifier	Modifier Description
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.
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)

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

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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