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

MassHealth
Transmittal Letter PHY- 154
July 2017

TO: Physicians Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: ***Physician Manual*** **(Regulatory Updates -- Midlevel Practitioner Project and EO562 Regulation Review; Subchapter 6 Updates)**

This letter transmits revisions to the MassHealth Physician regulations at 130 CMR 433.000, and to Subchapter 6 of the *Physician Manual*. These revisions are primarily related to the implementation of MassHealth's midlevel practitioner project. MassHealth has revised the Medical Practitioner enrollment application (PE-MP) and checklist (PE-MP-CL) in preparation for the new midlevel provider implementation.

- New midlevel providers have been encouraged since early June 2017 to submit their enrollment applications prior to the effective date of August 1, 2017.
- The new Medical Practitioner enrollment application (PE-MP) and checklist (PE-MP-CL) are available from the MassHealth Customer Service Center upon request by e-mail at providersupport@mahealth.net or by phone at 1-800-841-2900.

The revisions also incorporate certain additional updates resulting from an overall review of 130 CMR 433.000. MassHealth will now also begin paying for physician medical direction of certified registered nurse anesthetists, as described in the updated regulations and Subchapter 6.

The regulatory changes and the updates to Subchapter 6 of the *Physician Manual* are summarized below. All updates are **effective for dates of service on and after August 1, 2017.**

I. Regulatory Updates

A. Midlevel Practitioner Amendments

The midlevel practitioner-related updates are being implemented primarily through amendments to the MassHealth Physician program regulations at 130 CMR 433.000, with conforming updates to the Administrative and Billing Regulations (130 CMR 450.000) and regulations governing Managed Care Requirements for members (130 CMR 508.000).[1]

[1] Rates under the relevant EOHHS rate regulations that apply to these services are also being simultaneously updated, effective with dates of service on and after August 1, 2017. These regulations are: 101 CMR 316.00 (Surgery and Anesthesia); 101 CMR 317.00 (Medicine) and 101 CMR 318.00 (Radiology).

(1) State-Licensed Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) – Participation in MassHealth

MassHealth's midlevel practitioner project expands the types of providers eligible to participate in MassHealth to include all categories of state-licensed advanced practice registered nurses (APRNs), as well as physician assistants, and also allows physician assistants to serve as primary care providers in MassHealth's Primary Care Clinician (PCC) plan in accordance with M.G.L. c. 176S.[2]

- Physician Assistants (PA) must be a member of a group practice that also has at least one supervising physician as a member of that same group. PAs cannot bill for their own services due to Massachusetts licensure requirements; therefore, only the group practice will be able to bill for PA services (must use the PA's NPI as rendering provider). Physicians may no longer bill for the services of PAs, and the **HN** modifier has been removed from subchapter 6 to the *Physician's Manual*.
- Certified registered nurse anesthetists (CRNAs), psychiatric clinical nurse specialists (PCNSs), and clinical nurse specialists (CNSs) are now eligible to participate as independent MassHealth providers. Certified nurse practitioners (NPs) and certified nurse midwives (NMWs) will continue to be eligible to participate as independent MassHealth providers. Only NPs may be independent or non-independent.
- NMWs, Independent NPs, CRNAs, PCNSs, and CNSs can bill for their own services, or a group practice can bill for their services (must use the applicable APRN's NPI as rendering provider). Physicians may not bill for their services.
- Non-Independent NP services are billable by a physician employer (must use the physician's NPI ***and*** modifier **SA**). Non-Independent NPs and group practices cannot bill for their services.
- There is no separate payment under MassHealth for CRNA, PCNS, CNS, NMW, Independent NP, Non-Independent NP, or PA services if the practitioner (or group practice in which the practitioner is a member, as applicable) is employed by the hospital or other facility in which the APRN or PA services were performed, or if payment is otherwise made by the hospital or other facility for the services. MassHealth also does not separately pay hospitals for professional services of APRNs or PAs provided in an inpatient or outpatient hospital setting.

New or updated provider eligibility requirements and conditions of payment for each of these provider types were added or amended within the regulations. The **Midlevel Practitioner chart** below provides a summary of these updates, along with certain billing requirements. Providers must refer to the applicable regulations and Subchapter 6 of the *Physician Manual* for the full requirements.

[2] This transmittal letter does not address the limited participation of providers enrolling through the streamlined non-billing provider application process.

Midlevel Practitioners

Type of Midlevel Practitioner	Eligible to Participate in MassHealth?	Who can bill for services?	Can they be a primary care provider in the PCC Plan?	Other requirements of note (non-exhaustive)
State-Licensed Advanced Practice Registered Nurses				
1. Certified Registered Nurse Anesthetist (CRNA)	Yes Provider eligibility requirements and conditions of payment are at 130 CMR 433.454, and elsewhere in 130 CMR 433.000 and 450.000, as applicable.	CRNA or group practice CRNA must be fully enrolled in MassHealth if billing for his/her own services or if a group practice bills. If group practice bills, it must use CRNA's NPI as rendering provider. To bill, group practice must be enrolled in MassHealth and CRNA must be enrolled with MassHealth as part of that group	No. Note: Regulations at 130 CMR 450.118(J)(5)(k)2 were amended to exempt CRNA services from the PCC referral requirement (like anesthesiologist services).	As a condition of payment, CRNA services must be provided under the supervision of a physician, such that the operating physician or an anesthesiologist is immediately available if needed.
2. Psychiatric Clinical Nurse Specialist (PCNS)	Yes Provider eligibility requirements and conditions of payment are at 130 CMR 433.428, and elsewhere in 130 CMR 433.000 and 450.000, as applicable.	PCNS or group practice PCNS must be fully enrolled in MassHealth if billing for his/her own services or if a group practice bills. If group practice bills, it must use PCNS's NPI as rendering provider. To bill, group practice must be enrolled in MassHealth and PCNS must be enrolled with MassHealth as part of that group	No.	
3. Clinical Nurse Specialist (CNS)	Yes Provider eligibility requirements and conditions of payment are at 130 CMR 433.473, and elsewhere in 130 CMR 433.000 and 450.000, as applicable.	CNS or group practice CNS must be fully enrolled in MassHealth if billing for his/her own services or if a group practice bills. If group practice bills, must use CNS's NPI as rendering provider To bill, group practice must be enrolled in MassHealth and CNS must be enrolled with MassHealth as part of that group	No.	

Type of Midlevel Practitioner	**Eligible to Participate in MassHealth?**	**Who can bill for services?**	**Can they be a primary care provider in the PCC Plan?**	**Other requirements of note (non-exhaustive)**
4. Certified Nurse Midwife (NMW)	Yes. Provider eligibility requirements and conditions of payment are at 130 CMR 433.419, and elsewhere in 130 CMR 433.000 and 450.000, as applicable.	NMW or group practice NMW must be fully enrolled in MassHealth if billing for his/her own services or if a group practice bills. If group practice bills, must use NMW's NPI as rendering provider To bill, group practice must be enrolled in MassHealth and NMW must be enrolled with MassHealth as part of that group Note: Physicians can no longer bill for services of an employed NMW.	No.	
5. Independent Certified Nurse Practitioner (Independent NP)	Yes Provider eligibility requirements and conditions of payment are at 130 CMR 433.433, and elsewhere in 130 CMR 433.000 and 450.000, as applicable. NP must either be in a solo private practice or member of a group practice in order to be an "Independent NP." NPs employed by an individual physician cannot be an Independent NP. (See 130 CMR 433.433(C)). .	Independent NP or group practice Independent NP must be fully enrolled in MassHealth if billing for his/her own services or if a group practice bills. If group practice bills, must use Independent NP's NPI as rendering provider To bill, group practice must be enrolled in MassHealth and Independent NP must be enrolled with MassHealth as part of that group	Yes, either independently or as a primary care provider in an organizational PCC (CHC, HLHC, Hospital OPD, Group Practice, Indian Health Service). Provider eligibility requirements that an Independent NP must meet in order to serve as a PCC under the MassHealth PCC Plan are primarily set forth in 130 CMR 450.118.	

Type of Midlevel Practitioner	Eligible to Participate in MassHealth?	Who can bill for services?	Can they be a primary care provider in the PCC Plan?	Other requirements of note (non-exhaustive)
6. Non-Independent Certified Nurse Practitioner (Non-Independent NP)	Not fully participating provider; physician employer bills for their services. Non-Independent NP cannot be in a group practice or in a solo private practice. Must enroll in MassHealth as a non-billing provider. Applicable requirements and conditions of payment are at 130 CMR 433.433 and elsewhere in 130 CMR 433.000 and 450.000, as applicable.	Participating MassHealth physicians can bill for services of their employed Non-Independent NPs. Physician employer must bill using the physician's NPI, **and** modifier SA. Physician employer must be practicing as an individual physician (one who is not practicing as a professional corporation or as a member of a group practice). See 130 CMR 433.433(E). Note: a group practice cannot bill for Non-Independent NP services, either directly or through a physician's (or another group member's) NPI.	No.	
Physician Assistant (PA)	Yes, but PA must be in a group practice that also has at least one physician member. Provider eligibility requirements and conditions of payment are at 130 CMR 433.434, and elsewhere in 130 CMR 433.000 and 450.000, as applicable. Note: Due to Massachusetts licensure requirements, MassHealth does not pay PAs directly for their services.	Only a group practice can bill for PA services. Group practice must bill using the PA's NPI as rendering provider. Group practice must be enrolled in MassHealth, and the PA and the supervising physician must be enrolled with MassHealth as part of that group practice. Physicians cannot bill for PA services and group practice cannot bill for PA's services using physician's NPI.	Yes, as a primary care provider in a group practice that also employs at least one supervising PCC-eligible physician Additional provider eligibility requirements that a PA and the group practice must meet in order to serve as a PCC under the MassHealth PCC Plan are primarily set forth in 130 CMR 450.118.	All PA services must be provided pursuant to a formal supervisory arrangement with the physician, as further described under 263 CMR 5:00 and 130 CMR 433.434(D).

(2) Payment for CRNA services and Medical Direction of CRNA services

Along with allowing CRNAs to enroll as MassHealth providers, MassHealth has also updated the payment provisions in the Physician regulations (130 CMR 433.454) to allow payment to CRNAs and anesthesiologists for "**personally performed anesthesia services**," and for physician "**medical direction**" of CRNAs, as each of these terms are defined in the regulations.[3] Corresponding updates were also made to Subchapter 6 of the *Physician Manual* to add or update relevant modifiers that providers must use to claim payment for these services (see Section II, below).

[3] The applicable EOHHS rate regulations for surgery and anesthesia services are also being simultaneously updated to implement this payment method (see 101 CMR 316.00).

The **updated payment methodology** utilizes the **following five modifiers** that CRNAs (or group practices billing for CRNA services) and anesthesiologists must use to claim appropriate payment: **AA, QK, QY, QX and QZ.**

Payment for "personally performed anesthesia services"

- "**Personally performed anesthesia services**" is defined in the updated regulations at 130 CMR 433.454(A)(4).

- Payment for "personally performed anesthesia services," by a CRNA **not** employed by the facility in which the anesthesia services are provided, *or* by an anesthesiologist, is 100% of the total anesthesia fee. **Appropriate modifiers** are **QZ** (for a CRNA); and **AA** (for an anesthesiologist).

- If a CRNA **is** employed by the facility in which the "personally performed anesthesia service" is provided, there is no separate payment for the CRNA's services. **No claim** can be submitted **for the CRNA services** in this case.

Payment for anesthesia services when there is "medical direction"

- "**Medical direction**" is defined in the updated regulations at 130 CMR 433.454(C).

- If an anesthesiologist provides "medical direction" of a CRNA who is **not** employed by the facility in which the anesthesia services are performed, payment for the anesthesiologist's services is 50% of the total anesthesia fee, and payment for the CRNA's services is 50% of the total anesthesia fee. **Appropriate modifiers** are **QX** (for the CRNA); and **QY or QK**, **as applicable** (for an anesthesiologist providing medical direction).

- If an anesthesiologist provides "medical direction" of a **CRNA employed by** a facility in which the anesthesia service is performed, payment for the anesthesiologist's services is 50% of the total anesthesia fee and there is no separate payment for the CRNA's services. **No claim** can be submitted **for the CRNA's services** in this case. **Appropriate modifiers** are **QY or QK**, **as applicable** (for an anesthesiologist providing medical direction).

No payment for* "medical *supervision": MassHealth does **not** pay for "medical supervision" of anesthesia services, as defined in 130 CMR 433.454(D). See 130 CMR 433.454(A)(5).

(3) Additional Midlevel Practitioner-Related Regulatory Updates

- ***Amendments to conform with state licensure / BORIN regulations; other enrollment-related regulatory updates.*** Amendments update relevant language to align with current state licensure regulations; they also clarify requirements for out-of-state midlevel practitioners and make conforming changes to service descriptions and other areas to align with enrollment of midlevel practitioners.
- ***Updated Lists of Covered Services***. CRNA, PCNS, CNS and PA services have been added to the lists of covered services for applicable MassHealth coverage types in the Administrative and Billing Regulations (130 CMR 450.000), and language was updated to utilize current terminology for NMWs and NPs.

B. Other Physician Regulation Updates

MassHealth has also made the following changes to as a result of MassHealth's regulatory review of the Physician regulations (130 CMR 433.000):

- Updated definitions, including to delete unused or obsolete terms;
- Updated citations to the applicable EOHHS rate setting regulations;
- Updated the prior authorization section to require practitioners to follow MassHealth requirements regarding prior authorization, ordering, referrals and prescriptions;
- Streamlined the regulations to eliminate service descriptions that are more fully and appropriately addressed in other provider type regulations;
- Aligned same day service program integrity rules with the National Correct Coding Initiative and MassHealth guidance issued in July 2013.
- Updated service descriptions, including tobacco cessation, clinical laboratory, fluoride varnish, and pharmacy services to align with enrollment of midlevel practitioners;
- Updated the psychiatric services provisions;
- Clarified the global obstetrical fee; and
- Made updates to increase clarity and remove outdated language and policy.

II. Updates to Subchapter 6

This letter also transmits updates to Subchapter 6 of the *Physician Manual* to incorporate changes to codes and modifiers primarily related to the midlevel practitioner project.

A. Modifier Updates

Anesthesia Services Modifiers:

MassHealth has added or updated applicable modifiers in Section 605 of Subchapter 6 to correspond to the new MassHealth payment method for "personally performed anesthesia services" and physician "medical direction" of CRNA services. (See also Section I.A.(2), above).

The **updated anesthesia services modifiers and descriptions** are as follows:

- **AA:** Anesthesia services performed personally by an anesthesiologist. (This allows payment of 100% of the Total Anesthesia Fee for the anesthesiologist's services.)
- **QK:** Medical direction by a physician of two, three, or four concurrent anesthesia procedures. (Use to indicate physician medical direction of multiple CRNAs. This allows payment of 50% of the Total Anesthesia Fee for the physician's services.)
- **QY:** Medical direction of one CRNA by a physician. (Use to indicate physician medical direction of one CRNA. This allows payment of 50% of the Total Anesthesia Fee for the physician's services.)
- **QX:** CRNA anesthesia services with medical direction by a physician. (Use to indicate CRNA anesthesia services with medical direction by a physician. This allows payment of 50% of the Total Anesthesia Fee for the CRNA's services. Not for use if CRNA is employed by the facility in which the anesthesia services were performed.)
- **QZ:** CRNA anesthesia services without medical direction by a physician. (This allows payment of 100% of the Total Anesthesia Fee for the CRNA's services. Not for use if CRNA is employed by the facility in which the anesthesia services were performed).

Deleted modifiers

As part of the implementation of the midlevel practitioner project, **the following two modifiers had been removed** from Subchapter 6 as unnecessary:

- **HN:** Bachelors 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.)
- **SB:** Nurse midwife (This modifier is to be applied to codes for services billed by a physician that were performed by a nonindependent 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.)

Other Modifier-Related Updates:

The modifier descriptions were otherwise updated to align with the MassHealth midlevel practitioner updates, updated MassHealth and State licensing board requirements, and to reflect MassHealth changes related to independent billing for APRN services.

B. Other Subchapter 6-Related Updates

Additional Drug Codes

MassHealth has expanded the list of J codes in Subchapter 6 of the *Physician Manual* to separately list additional codes for certain physician-administered drugs that were previously paid using J3490 or J3590. The additional J codes correspond to certain physician-administered drugs that are listed on the MassHealth Drug List. For proper payment, providers should now bill using these separate J codes, as appropriate, rather than using J3490 or J3590.

Drugs, Vaccines and Immune Globulin Pricing Updates

Rates paid under the MassHealth Physician program for covered codes under the Physician Subchapter 6 for drugs, vaccines and immune globulins administered in a physician's office, are as specified in 101 CMR 317.00: *Medicine*. Subject to any other applicable provision in 101 CMR 317.00, the payment rates for these MassHealth-covered codes for drugs, vaccines and immune globulins administered in the physician's office, are equal to the fees listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (see 101 CMR 317.03(1)(c)2 and 317.04(1)(a)). For applicable codes for drugs, vaccines, and immune globulins administered in a physician's office that are listed in Section 603 or 604 of the Physician Subchapter 6 with "IC," payment set by Individual Consideration will apply until such time as the code is listed and a rate set in the Quarterly ASP Medicare Part B Drug Pricing File, consistent with 101 CMR 317.04(1)(a). This will occur automatically, without MassHealth issuing another Subchapter 6 update.

Service Code Descriptions

MassHealth has also streamlined Subchapter 6 of the *Physician Manual* to remove the descriptions for certain codes. MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology (CPT) 2017* codebook, or the HCPCS Level II Codebook, as applicable, for the service code descriptions when billing for services provided to MassHealth members.

NEW MATERIAL

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

Physician Manual
Pages 4-1 through 4-44
Pages 6-27 through 6-30

OBSOLETE MATERIAL

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

Physician Manual
Pages 4-1 through 4-4, 4-7 through 4-10, and 4-41— transmitted by Transmittal Letter PHY-142
Pages 4-11, 4-12, 4-25, and 4-26— transmitted by Transmittal Letter PHY-124
Pages 4-13, 4-14, and 4-35 through 4-40— transmitted by Transmittal Letter PHY-149
Pages 15 and 4-16— transmitted by Transmittal Letter PHY-137
Pages 4-17, 4-18, 4-23, 4-24— transmitted by Transmittal Letter PHY-109
Pages 4-19 through 4-22— transmitted by Transmittal Letter PHY-116
Pages 4-27 through 4-30, and 4-43 and 4-44— transmitted by Transmittal Letter PHY-137
Pages 4-31 and 4-32— transmitted by Transmittal Letter PHY-111
Pages 4-33 and 4-34— transmitted by Transmittal Letter PHY-140
Pages 6-1 through 6-26— transmitted by Transmittal Letter PHY-152
Pages 6-27 through 6-30 — transmitted by Transmittal Letter PHY-153

4. Program Regulations

Part 1. General Information

Part 2. Medical Services

4. Program Regulations (cont.)

Part 3. Surgery Services

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.

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.

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 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-Licensed Health Center (HLHC) – a facility that

(1) operates under a hospital's license but is not physically attached to the hospital;
(2) is subject to the fiscal, administrative, and clinical management of the hospital;
(3) provides services to patients solely on an outpatient basis;
(4) demonstrates CMS provider-based status in accordance with 42 CFR 413.65;
(5) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
(6) is enrolled with the MassHealth agency as a hospital-licensed health center.

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.

Midlevel Practitioner – a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, psychiatric clinical nurse specialist, and physician assistant. In general, subject to compliance with state and federal law, the requirements and limitations in 130 CMR 433.000 that apply to a physician, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage, also apply to midlevel practitioners.

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.

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.

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.

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.

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.
(3) Provider participation requirements for certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, psychiatric clinical nurse specialists, and physician assistants are also addressed in this 130 CMR 433.000.

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

(B) 101 CMR 316.00: *Surgery and Anesthesia Services*

(C) 101 CMR 317.00: *Medicine*

(D) 101 CMR 318.00: *Radiology*

(E) 101 CMR 320.00: *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) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.
(2) 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, Orders, Referrals, and Prescriptions

(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 behavioral health 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*.

(E) Therapy Services Requiring Prior Authorization. Prior authorization is required for the following therapy services provided by any MassHealth provider to eligible MassHealth members.

(1) more than 20 occupational therapy visits or 20 physical-therapy visits, including group therapy visits, for a member within a 12 month period; and

(2) more than 35 speech/language therapy visits, including group therapy visits, for a member within a 12-month period.

(F) Other Services Requiring Prior Authorization, Orders, Referrals, or Prescriptions. Many other services require prior authorization, or must first be ordered, referred, prescribed, or otherwise have their need substantiated by a physician or other practitioner before the MassHealth agency will cover the service. When such a service is medically necessary for an eligible MassHealth member, a treating physician or other practitioner shall provide such orders, referrals, prescriptions, medical necessity documentation, certifications, plans of care, examinations, or take such other actions that the MassHealth agency requires as a condition of payment for the service. Coverage requirements for particular MassHealth services are contained in the applicable MassHealth program regulations and guidance and are found in the MassHealth Provider Library. These services include, but are not limited to, the following:

(1) transportation;
(2) drugs;
(3) home health services;
(4) nursing facility services;
(5) durable medical equipment; and
(6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. Payment for maintaining the member's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care provided to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will disallow payment for the claimed service.

(C) The MassHealth agency may at its discretion request, and upon such request the physician must provide, any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, §38, and 130 CMR 450.205: *Recordkeeping and Disclosure*. The MassHealth agency may produce, or at its option may require the physician to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following:

(a) the member's name and date of birth;
(b) the date of each service;
(c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(d) the member's medical history;
(e) the diagnosis or chief complaint;
(f) clear indication of all findings, whether positive or negative, on examination;
(g) any medications administered or prescribed, including strength, dosage, and regimen;
(h) a description of any treatment given;
(i) recommendations for additional treatments or consultations, when applicable;
(j) any medical goods or supplies dispensed or prescribed;
(k) any tests administered and their results; and
(l) for members under the age of 21 who are being treated by a physician or psychiatric clinical nurse specialist, a CANS completed during the initial behavioral-health assessment and updated at least once every 90 days thereafter.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care provided to a member must be included for each date of service or service code claimed for payment, along with any data that update the member's medical course.

(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record will be deemed to document services provided to members and billed to the MassHealth agency if it conforms to and satisfies the medical record requirements set forth in 105 CMR 130.000: *Licensure of Hospitals*. The physician claiming payment for any hospital inpatient visit service is responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical record requirements for radiology, psychiatry, and other services can be found in the applicable sections of 130 CMR 433.000.

(G) Compliance with the medical record requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 will be determined by a peer-review group designated by the MassHealth agency as set forth in 130 CMR 450.206: *Determination of Compliance with Medical Standards*. The MassHealth agency will refuse to pay or, if payment has been made, will consider such payment to be an overpayment as defined in 130 CMR 450.235: *Overpayments* subject to recovery, for any claim that does not comply with the medical record requirements established or referred to in 130 CMR 433.000. Such medical record requirements constitute the standard against

which the adequacy of records will be measured for physician services, as set forth in 130 CMR 450.205(B): *Recordkeeping and Disclosure*.

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment for any service that is listed in Subchapter 6 of the *Physician Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(B) Operative Report. For surgery procedures designated in Subchapter 6 of the *Physician Manual* as requiring individual consideration, the provider must attach operative notes to the claim. An operative report must state the operation performed, the name of the member, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and surgical assistants, and the technical procedures performed.

433.411: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted as described in 130 CMR 433.429, the physician or psychiatric clinical nurse specialist must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

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

The MassHealth agency pays for all medically necessary physician services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction,* without regard to service limitations described in 130 CMR 433.000, and with prior authorization.

Part 2. Medical Services

433.413: Office Visits: Payment Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per member per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure for the same member on the same date when the office visit and the treatment/procedure are performed in the same location. This limit does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the treatment/procedure. This limitation does not apply to tobacco cessation counseling services provided by a physician or a qualified staff member under the supervision of a physician on the same day as a visit. This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (see 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit.

(C) Immunization or Injection.

(1) The physician may bill for either an office visit or vaccine administration, but may not bill for both an office visit and vaccine administration for the same member on the same date when the office visit and the vaccine administration are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the vaccine was administered.

(2) The MassHealth agency pays for the cost of the injectable material unless the Massachusetts Department of Public Health distributes the injectable material free of charge.

(D) Family Planning Office Visits. The MassHealth agency pays for office visits provided for the purposes of family planning. The MassHealth agency pays for any family planning supplies and medications dispensed by the physician at the physician's acquisition cost. To receive payment for the supplies and medications, the provider must attach to the claim a copy of the actual invoice from the supplier.

433.414: Outpatient Hospital Services: Payment Limitations

(A) Time Limit. Payment for outpatient hospital visits is limited to one outpatient hospital visit per day per member per physician.

(B) Visit and Treatment/Procedure.

(1) The physician may bill for either a hospital outpatient visit, or for a treatment/procedure during a hospital outpatient visit, but may not bill for both a visit and a treatment/procedure for the same member on the same date at the same hospital. This limitation does not apply to a significant, separately identifiable outpatient hospital visit provided by the same physician on the same day as the procedure or other service.

(2) The MassHealth agency pays either a physician or an outpatient hospital, but not both, for physician services provided in an outpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an outpatient hospital setting.

(3) An outpatient hospital setting includes a hospital's outpatient department, emergency department, HLHC, and any other satellite of the hospital. A hospital outpatient visit includes a visit to any outpatient hospital setting.

433.415: Inpatient Hospital Services: Service Limitations and Screening Requirements

(A) Hospital inpatient visit fees apply to visits by physicians to members hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per member for the length of the member's hospitalization.

(B) The MassHealth agency does not routinely pay for visits to members who have undergone or who are expected to undergo surgery, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, the MassHealth agency does pay for such visits.

(C) The MassHealth agency pays only the attending physician for inpatient hospital visits, with the following exceptions.

(1) The MassHealth agency pays for consultations by a physician other than the attending physician. (See 130 CMR 433.418 for regulations about consultations.)

(2) If it is necessary for a physician other than the attending physician to treat a hospitalized member, the other physician's services are payable. An explanation of the necessity of such

visits must be attached to the claim. The MassHealth agency will review the claim and determine appropriate payment to the other physician.

(D) The MassHealth agency pays either a physician or an inpatient hospital, but not both, for physician services provided in an inpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an inpatient hospital setting.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The MassHealth agency seeks to ensure that a MassHealth member receives nursing facility services only when available alternatives do not meet the member's need, and that every member receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.409: *Nursing Facility: Services Requirement for Medical Eligibility* through 456.411: *Nursing Facility: Review of Need for Continuing Care in a Nursing Facility*.

(B) Service Limitations. Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a member's home is limited to one visit per member per day.

433.418: Consultations: Service Limitations

The MassHealth agency pays for only one initial consultation per member per case episode. Additional consultation visits per episode are payable as follow-up consultations.

433.419: Certified Nurse Midwife Services

(A) General. 130 CMR 433.419 applies specifically to certified nurse midwives (also known as nurse midwives). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse midwives, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays a certified nurse midwife or group practice for certified nurse midwife services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the certified nurse midwife or group practice is not an employee of the hospital or other facility in which the certified nurse midwife services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) the certified nurse midwife participates in MassHealth pursuant to the requirements of 130 CMR 433.419(C)); and

(4) for an out of state certified nurse midwife the requirements of 130 CMR 433.403(C) are met.

(C) Certified Nurse Midwife Provider Eligibility. Any certified nurse midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(1) is licensed to practice as a certified nurse midwife by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse midwife services are provided; and

(2) is a member of a group practice or is in a solo private practice;

(D) Consultation Between a Certified Nurse Midwife and Physician. The MassHealth agency does not pay for a consultation between a certified nurse midwife and a physician as a separate service.

433.420: Obstetric Services: Introduction

The MassHealth agency offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available to a provider for all covered obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met.

433.421: Obstetric Services: Global-Fee Method of Payment

(A) Definitions

(1) Coverage Provider. a physician, certified nurse midwife, physician assistant, or certified nurse practitioner that is either a member of the same group practice as the Primary Provider, or who is in a separate practice from the Primary Provider and has a back-up coverage arrangement with the Primary Provider.

(2) Global Fee. a single inclusive fee for all prenatal and postpartum visits, and the delivery. The global fee is available only when the conditions in 130 CMR 433.421 are met.

(3) Non-coverage Provider. any provider that has no employment, contractual, or practice-coverage relationship with the Primary Provider, or his or her practice.

(4) Primary Provider. a physician or certified nurse midwife who has assumed responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for a member.

(B) Conditions for Global Fee.

(1) Primary Provider Responsibilities. In order to qualify for payment of the global fee, the primary provider must perform, or coordinate a coverage provider's performance of, a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for the member, and must also satisfy all other requirements in 130 CMR 433.421. The primary provider is the only clinician that may claim payment of the global fee. As an exception to 130 CMR 450.301(A): *Claims* and 130 CMR 433.451(A), the primary provider is not required to perform all components of the obstetric global service directly. All global-fee claims must use the delivery date as the date of service.

(2) Standards of Practice. All of the components of the obstetric global service must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

(3) Coordinated Medical Management. The primary provider or coverage provider must coordinate the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

(a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;
(b) coordination of medical management with necessary referral to other medical specialties and dental services; and
(c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

(4) Health-Care Counseling. In conjunction with providing prenatal care, the primary provider or coverage provider must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:
(a) EPSDT screening for teenage pregnant women;
(b) smoking and substance abuse;
(c) hygiene and nutrition during pregnancy;
(d) care of breasts and plans for infant feeding;
(e) obstetrical anesthesia and analgesia;
(f) the physiology of labor and the delivery process, including detection of signs of early labor;
(g) plans for transportation to the hospital;
(h) plans for assistance in the home during the postpartum period;
(i) plans for pediatric care for the infant; and
(j) family planning.

(5) Obstetrical-Risk Assessment and Monitoring. The primary provider or coverage provider must manage the member's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services are paid separately from the global fee and should be billed for by the servicing provider on a fee-for-service basis. Such services may include, but are not limited to, the following:
(a) counseling specific to high-risk patients (for example, antepartum genetic counseling);
(b) evaluation and testing (for example, amniocentesis); and
(c) specialized care (for example, treatment of premature labor).

(C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.
(1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and a minimum of one postpartum visit) are provided directly by the primary provider, or a coverage provider. (This constitutes an exception to 130 CMR 450.301(A): *Claims* and 130 CMR 433.451(A).)
(2) If the primary provider bills for the global fee, no coverage provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and to all coverage providers who provided components of the obstetric global service .
(3) If the primary provider bills for the global fee, any non-coverage provider who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no non-coverage provider may claim payment for the delivery.
(4) If the primary provider bills on a fee-for-service basis and does not bill a global fee, any other coverage or non-coverage provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services they provided to the same member.

(D) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a global fee. This includes services performed by the primary provider and any coverage providers. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each member's record in a way that allows for easy review of her obstetrical history.

(130 CMR 433.422 and 433.423 Reserved)

433.424: Obstetric Services: Fee-for-Service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by the MassHealth agency as an alternative to the global fee referenced in 130 CMR 433.421. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(C) When a certified nurse midwife is the primary provider and a physician performs a cesarean section, the certified nurse midwife may claim payment for the prenatal visits only on a fee-for-service basis. The operating physician may claim payment for the cesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services

The MassHealth agency pays for ophthalmic materials in accordance with the vision care regulations at 130 CMR 402.000: *Vision Care*. The MassHealth agency pays for eye examinations subject to the following limitations.

(A) Comprehensive Eye Examinations.
(1) The MassHealth agency does not pay for a comprehensive eye examination if the service has been provided
(a) within the preceding 12 months, for a member under 21 years of age; or
(b) within the preceding 24 months, for a member 21 years of age or older.
(2) The restrictions at 130 CMR 433.425(A)(1) do not apply if one of the following complaints or conditions is documented in the member's medical record:
(a) blurred vision;
(b) evidence of headaches;
(c) systemic diseases, such as diabetes, hyperthyroidism, or HIV;
(d) cataracts;
(e) pain;
(f) redness; or
(g) infection.

(B) Consultation Service. The MassHealth agency pays for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) Screening Services. The MassHealth agency does not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) Comprehensive Eye Examinations and Screening Services. A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the MassHealth agency pays for only the comprehensive eye exam.

(E) Tonometry. The MassHealth agency does not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, consultation, or screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code.

433.426: Audiology Services: Service Limitations

The MassHealth agency pays for audiology services only when they are provided either by a physician, or by an audiologist licensed or certified in accordance with 130 CMR 426.404: *Audiologist: Provider Eligibility* who is employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only.

433.427: Allergy Testing: Service Limitations

(A) The MassHealth agency pays for allergy testing only when performed by or under the direction of a physician, certified nurse practitioner or clinical nurse specialist, or by a physician assistant under a physician's supervision. All fees include payment for physician observation and interpretation of the tests in relation to the member's history and physical examination. An initial consultation and allergy testing for a member may be billed by the same provider on the same date of service.

(B) The MassHealth agency does not pay for more than three blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation per member per year.

(C) Immunotherapy and desensitization (extracts) are covered services. The provider must indicate the amount and anticipated duration of the supply for immunotherapy and desensitization (extracts) on the claim form.

(D) The MassHealth agency pays for follow-up office visits for injections and reevaluation as office visits.

(E) The MassHealth agency pays for sensitivity tests only once per member per year regardless of the type of tests performed or the number of visits required.

433.428: Psychiatric Services: Introduction

(A) Covered Services. The MassHealth agency pays a physician or a psychiatric clinical nurse specialist (PCNS) for the psychiatry services described in 130 CMR 433.428 and 130 CMR 433.429.

(B) Noncovered Services.

(1) Nonphysician and Non-PCNS Services. The MassHealth agency does not pay a physician or PCNS for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician or PCNS.

(2) Research and Experimental Treatment. The MassHealth agency does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) Nonmedical Services. The MassHealth agency does not pay a physician or a PCNS for nonmedical services, including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);

(d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other noncovered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The MassHealth agency does not pay for psychological testing provided by a physician or a PCNS.

(C) Services Provided by a Psychiatric Clinical Nurse Specialist (PCNS).

(1) General. 130 CMR 433.428 and 130 CMR 433.429 apply specifically to physicians and psychiatric clinical nurse specialists. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician, also apply to a psychiatric clinical nurse specialist (PCNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a PCNS or group practice for PCNS services when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to 244CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(b) the PCNS or group practice is not an employee of the hospital or other facility in which the PCNS services were performed, or is not otherwise paid by the hospital or facility for the service;

(c) the PCNS participates in MassHealth pursuant to the requirements of 130 CMR 433.428(C)(3); and

(d) for an out-of-state PCNS, the requirements of 130 CMR 433.403(C) are met.

(3) PCNS Provider Eligibility. Any PCNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(a) is licensed to practice as a PCNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the PCNS services are provided; and

(b) is a member of a group practice or is in a solo private practice.

(4) Consultation Between a PCNS and a Physician. The MassHealth agency does not pay for a consultation between a PCNS and a physician as a separate service.

(D) Recordkeeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;
(2) the member's diagnosis;
(3) the member's medical history;
(4) the member's social and occupational history;
(5) the treatment plan;
(6) the physician's or PCNS's short- and long-range goals for the member;
(7) the member's response to treatment; and
(8) if applicable, a copy of the signed consent for electroconvulsive therapy.

433.429: Psychiatric Services: Scope of Services

130 CMR 433.429 describes the services that a physician or a psychiatric clinical nurse specialist (PCNS) may provide, including the limitations imposed on those services by the MassHealth agency. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the member; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The MassHealth agency pays a physician or PCNS for individual psychotherapy provided to a member only when the physician or PCNS treats the member. This service includes diagnostics.

(B) Family and Couple Therapy. The MassHealth agency pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one fee per session, regardless of the number of family members present or the presence of a cotherapist.

(C) Group Psychotherapy.

(1) Payment is limited to one fee per group member with a maximum of 12 members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(D) Multiple-Family Group Psychotherapy.

(1) Payment is limited to one fee per group member with a maximum of ten members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for multiple-family group psychotherapy when it is performed as an integral part of a psychiatric day treatment program.

(E) Diagnostic Services. The MassHealth agency pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(F) Reevaluation. The MassHealth agency pays for the reevaluation of a member who has been out of treatment for at least six months. A provider may bill for a maximum of two one-hour units per member per calendar year for the purpose of designing a treatment plan.

(G) Long-Term Therapy. The MassHealth Agency defines long-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to extend more than 12 sessions.

(H) Short-Term Therapy. The MassHealth agency defines short-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to terminate within 12 sessions.

(I) Medication Review. The MassHealth agency pays for a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist, or PCNS, or administration of prescribed intramuscular medication by a physician or a PCNS. If this service is not combined with psychotherapy, it must be billed as a minimal office visit. The MassHealth agency does not pay separately for medication review if it is performed on the same day as another service, except for psychotherapy for crisis.

(J) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another entity.

(2) The MassHealth agency pays for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the member's record. Such circumstances are limited to situations in which both the physician or PCNS and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face to face communication would impede a coordinated treatment program.

(3) The MassHealth agency does not pay for court testimony.

(K) Family Consultation. The MassHealth agency pays for consultation with the natural or foster parent or legal guardian of a member less than 21 years of age who lives with the child and is responsible for the child's care, and who is not an eligible member, when such consultation is integral to the treatment of the member.

(L) Psychotherapy for Crisis Services. The MassHealth agency pays for psychotherapy for crisis as defined as an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

(1) This service is limited to face-to-face contacts with the member; psychotherapy for crisis service via telephone contact is not a reimbursable service.

(2) The need for psychotherapy for crisis services must be fully documented in the member's record for each date of psychotherapy for crisis services.

(3) This service is limited to one initial unit of service and up to three add-on units of service per date of service.

(M) Electroconvulsive Therapy. The MassHealth agency pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician or PCNS and only when the physician or PCNS as well as the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(N) After-Hours Telephone Service. The physician or PCNS must provide telephone coverage during the hours when the physician or PCNS is unavailable, for members who are in a crisis state.

(O) Acute Hospital Inpatient Visit. A visit to a hospitalized member in an acute hospital is payable only as a hospital visit (see 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided. Payment will be made for only one visit per member per day.

(P) Frequency of Treatment. The MassHealth agency pays a physician or a PCNS for only one session of a single type of service provided to an individual member on a single date of service. Return visits on the same date of service are not reimbursable except for the provision of psychotherapy for crisis services, as described 433.429(L). The MassHealth agency pays a physician or a PCNS for more than one mode of therapy provided to a member during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment must be documented in the member's record.

(Q) Child and Adolescent Needs and Strengths (CANS). Any physician or PCNS who provides individual, group, or family therapy to members under the age of 21 must be certified every two years according to the process established by the Executive Office of Health and Human Services (EOHHS) to administer the CANS, must use the CANS during initial behavioral-health assessments before the initiation of therapy, and must update the CANS at least every 90 days thereafter during the treatment review process.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Medicare is the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Members being treated for chronic renal disease must be referred to a MassHealth Enrollment Center or their Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. The MassHealth agency pays for hemodialysis only to hospitalized members who are

(1) being dialyzed for acute renal failure;

(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or

(3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician, subject to all general conditions of payment, including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth in accordance with regulations at 130 CMR 430.000: *Rehabilitation Center Services* and 432.000: *Therapist Services*.

(C) (1) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 433.431(C)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed physician or licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a nonphysician or non-therapist, must be documented in the medical record.

433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.

(C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed in addition to an office visit.

(E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.433: Certified Nurse Practitioner Services

(A) General. 130 CMR 433.433 applies specifically to certified nurse practitioners (also known as nurse practitioners). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse practitioners, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays either an independent certified nurse practitioner or group practice (in accordance with 130 CMR 433.433(C)), or the physician employer of a nonindependent certified nurse practitioner (in accordance with 130 CMR 433.433(E)), for certified nurse practitioner services when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the certified nurse practitioner or group practice is not an employee of the hospital or other facility in which the certified nurse practitioner services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) (a) in the case of payment claimed by an independent certified nurse practitioner, or a group practice, the certified nurse practitioner participates in MassHealth pursuant to the requirements of 130 CMR 433.433(C); or

(b) in the case of payment claimed by a physician employer of a nonindependent certified nurse practitioner, the conditions of 130 CMR 433.433(E) are met; and

(4) for an out of state certified nurse practitioner the requirements of 130 CMR 433.403(C) are met.

(C) Independent Certified Nurse Practitioner Provider Eligibility: Submission Requirements. Only a certified nurse practitioner who meets the following requirements may enroll in MassHealth as an independent certified nurse practitioner:

(1) is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are provided; and

(2) is a member of a group practice or is in a solo private practice.

(3) Any certified nurse practitioner applying to participate as an independent provider in MassHealth must submit documentation satisfactory to the MassHealth agency that he or she meets these requirements.

(D) Consultation Between Certified Nurse Practitioner and Physician. The MassHealth agency does not pay for a consultation between a certified nurse practitioner and a physician as a separate service.

(E) Submitting Claims for Nonindependent Certified Nurse Practitioners. Any certified nurse practitioner who does not meet the requirements of 130 CMR 433.433(C)(2) is a nonindependent certified nurse practitioner and is not eligible to submit claims to MassHealth. As an exception to 130 CMR 450.301: *Claims*, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent certified nurse practitioner may submit claims for services provided by a nonindependent certified nurse practitioner employee, but only if:

(1) the nonindependent certified nurse practitioner is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are performed;

(2) such services are provided in accordance with 130 CMR 433.433(B); and

(3) payment is claimed by the physician employer in accordance with 130 CMR 450.301(B): *Claims*. (Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers.)

433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to physician assistants, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*).

(B) Conditions of Payment. In accordance with 263 CME: *Board of Registration of Physician Assistants*, the MassHealth agency does not pay physician assistants directly. The MassHealth agency pays a group practice employer of a physician assistant for physician assistant services. Physician assistant services are payable when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR: *Massachusetts Board of Registration of Physician Assistants* or of the state licensing agency of another state in which the services are provided);

(2) the physician assistant or group practice is not an employee of the hospital or other facility in which the physician assistant services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) the services are provided pursuant to a formal supervisory arrangement with a physician, as further described under 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants* and 130 CMR 433.434(D);

(4) the physician assistant participates in MassHealth pursuant to the requirements of 130 CMR 433.434(C); and

(5) for an out of state physician assistant the requirements of 130 CMR 433.403(C) are met.

(C) Physician Assistant Provider Eligibility. Any physician assistant applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(1) is licensed to practice as a physician assistant by the Massachusetts Board of Registration of Physician Assistants or by the licensing agency of another state in which the physician assistant services are provided; and

(2) is a member of a group practice comprising at least one physician.

(D) Supervisory Arrangement Requirements.

(1) The services of a physician assistant must be performed under the supervision of a physician in accordance with 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*.

(2) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

433.435: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 433.435(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000: *Pharmacy Services*.

(B) Tobacco Cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 433.435(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other health care providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including:

(i) a review of the health consequences of tobacco use and the benefits of quitting;

(ii) a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and

(iii) a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

(i) identification of personal risk factors for relapse and incorporation into the treatment plan;

(ii) strategies and coping skills to reduce relapse risk; and

(iii) a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

(i) the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and

(ii) the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services.

(1) Qualified Providers.

(a) Physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

(b) All other providers of tobacco cessation counseling services must complete a course of training in tobacco cessation counseling by a degree-granting institution of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all registered nurses and other individuals who qualify under 130 CMR 433.435(C)(1)(b) who are providers of tobacco cessation counseling services for whom the physician will submit claims.

(D) Tobacco Cessation Services: Claims Submission.

(1) Physicians, independent certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, and clinical nurse specialists, or group practice employers of such clinicians may submit claims for tobacco cessation services when those clinicians provide tobacco cessation services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for tobacco cessation services provided by the physician assistant. See Subchapter 6 of the *Physician Manual* for service code descriptions.

(2) As an exception to 130 CMR 450.301(A): *Claims*, a physician that is an employer of a non-independent certified nurse practitioner, registered nurse, or individual who qualifies under 130 CMR 433.435(C)(1)(b), may submit claims for tobacco cessation services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.435(B) and (C) and payment is claimed in accordance with 130 CMR 450.301(B): *Claims*.

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Services Provided by an Independent Diagnostic Testing Facility (IDTF). The MassHealth agency pays an IDTF as defined in 130 CMR 433.401 for applicable diagnostic tests in accordance with the independent diagnostic testing facility regulations at 130 CMR 431.000: *Independent Diagnostic Testing Facility* .

(B) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X rays must be labeled adequately with the following:

(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule. The MassHealth agency does not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X ray that was previously read and taken in a different hospital.

(B) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule.

(C) Surgical Introductions and Interpretations. The MassHealth agency pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is payable in accordance with the EOHHS fee schedule.
(2) In a single operative session:
    (a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the EOHHS fee schedule; and
    (b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.
(3) Interpretations are payable in accordance with the EOHHS fee schedule, up to a maximum of three.

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

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

433.438: Clinical Laboratory Services: Introduction

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

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or physician assistant, or by an independent clinical laboratory certified by Medicare.

(B) Payment. The MassHealth agency pays a physician, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or group practice employer of such practitioners or of a physician assistant only for laboratory tests performed in the practitioner's office. If an independent clinical laboratory performs laboratory tests for a member, the MassHealth agency pays only the laboratory for those services.

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

(1) a signed request for the laboratory services to be performed;
(2) the member's MassHealth identification number; and
(3) the physician's name, address, and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue).

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

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

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438, including but not limited to:

(1) tests performed to establish paternity;
(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and
(3) post-mortem examinations.

433.440: Acupuncture

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

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

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

(D) Provider Qualifications for Acupuncture.

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

(E) Conditions of Payment. The MassHealth agency pays physicians, physician employers of an acupuncturist (in accordance with 130 CMR 433.401(F)), independent nurse practitioners licensed in acupuncture, or independent nurse midwives licensed in acupuncture for acupuncture services when the:

(1) services are limited to the scope of practice authorized by state law or regulation (including but not limited to 243 CMR 5.00: *The Practice of Acupuncture*);
(2) the acupuncturist has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine; and
(3) services are provided pursuant to a supervisory arrangement with a physician.

(F) Acupuncture Claims Submissions.

(1) Physicians, independent nurse practitioners licensed in acupuncture, and independent nurse midwives licensed in acupuncture may submit claims for acupuncture services when they provide those services directly to MassHealth members or as an exception to 130 CMR 450.301(A): *Claims* when a licensed practitioner under the supervision of a physician provides those services directly to MassHealth members. See Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the physician, independent nurse practitioner licensed in acupuncture, or independent nurse midwife licensed in acupuncture may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

433.441: Pharmacy Services: Drugs Dispensed in Pharmacies

Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers, and related prescription requirements for prescribing prescribers, are governed by 130 CMR 406.000: *Pharmacy Services*.

(130 CMR 433.442 through 433.446 Reserved)

433.447: Drugs Administered in the Office (Provider-administered Drugs)

(A) Drugs and biologicals dispensed in the office are payable, subject to the exclusions and service limitations at 130 CMR 433.404, 433.406, and 130 CMR 406.413(B) and (C).

(B) The MassHealth agency does not pay a provider separately for drugs that are considered routine and integral to the delivery of a provider's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the provider's fee for the service.

(C) The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the provider has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization.

(D) Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of HCPCS units dispensed, NDC code, NDC units and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, a copy of the invoice showing the actual acquisition cost must be attached to the claim. Claims without this information are denied.

(E) The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with EOHHS regulations at 101 CMR 331.00: *Prescribed Drugs.*

(F) The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.

(G) Payment for drugs may be claimed in addition to an office visit.

(130 CMR 433.448 Reserved)

433.449: Fluoride Varnish Services

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

(B) Qualified Personnel. Physicians, certified nurse practitioners, clinical nurse specialists, 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) Fluoride Varnish Services: Claim Submission

(1) A provider 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.

(2) Physicians, independent certified nurse practitioners, and clinical nurse specialists or group practice employers of such clinicians, may submit claims for fluoride varnish services when those clinicians provide fluoride varnish services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for fluoride varnish services provided by the physician assistant. See Subchapter 6 of the Physician Manual for service code descriptions.

(3) As an exception to 130 CMR 450.301(A): *Claims*, a physician that is an employer of a non-independent certified nurse practitioner, registered nurse, licensed practical nurse, or medical assistant, may submit claims for fluoride varnish services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.449(A) and (B), and payment is claimed in accordance with 130 CMR 450.301(B): *Claims*.

(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 provider 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. The limitations in 130 CMR 433.452(A) do not apply to a significant, separately identifiable evaluation and management service provided by the same provider on the same day of the procedure or other services. For payment information about obstetrical care, refer to 130 CMR 433.421.

(B) Payment for Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services are included in the global surgical package regardless of setting, including but not limited to hospitals, ambulatory surgical centers, and office settings.

(1) The following services are included in the payment for a global surgery when furnished by the provider who performs the surgery:

(a) preoperative visits;
(b) intraoperative visits;
(c) complications following surgery;
(d) postoperative visits;
(e) postsurgical pain management;
(f) miscellaneous services related to surgery, including but not limited to dressing changes; local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes; and changes and removal of tracheostomy tubes; and
(g) visits related to the surgery to a patient in an intensive care or critical care unit, if made by the surgeon. Intensive or critical care visits unrelated to surgery are not included in the global surgical package.

(2) The following services are not included in the payment for a global surgery and are separately payable by MassHealth. *See* 130 CMR 433.600 for a listing of modifers, where applicable.

(a) the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
(b) services of other physicians except where the surgeon and the other physician or physicians agree on the transfer of care during the global period. Such transfer agreement must be in writing and a copy of the written transfer agreement must be kept in the member's medical record;
(c) visits unrelated to the diagnosis for which the surgical procedure is performed;
(d) treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the surgery;

(e) diagnostic tests and procedures, including diagnostic radiological procedures;
(f) clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications resulting from the surgery. A new postoperative period begins with the subsequent surgical procedure. This exception includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure;
(g) treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical that there would be insufficient time for transportation to an OR);
(h) a second, more extensive procedure required because the initial, less extensive procedure did not produce the desired outcome;
(i) immunotherapy management for organ transplants; and
(j) critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance by the physician.

(C) Payment for Multiple Surgeries. Multiple surgeries are separate procedures performed by a provider on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from intraoperative services and surgeries that are incidental to or components of a primary surgery (that is, bundled services). Bundled services are not paid separately. When two or more related procedures are performed on a patient during a single session or visit, the MassHealth agency pays the provider for the comprehensive code and denies or adjusts the component, incidental, or mutually exclusive procedure performed during the same session. The bundling guidelines that MassHealth applies are based upon generally accepted industry guidelines including, but not limited to the National Correct Coding Initiative administered through the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association's *Current Procedural Terminology (CPT)* code book. To receive payment for multiple surgeries, the provider must bill with the multiple surgery modifier. Additionally, the provider must use NCCI-related modifiers to receive payment, when appropriate, for two medically necessary, separately identifiable procedures performed on a member on the same date of service (*see* Subchapter 6 of the *Physician Manual* for a listing of allowed modifiers).

(D) Payment for Multiple Endoscopy Procedures. When multiple procedures are performed through the same endoscope, payment is made for the highest valued endoscopy procedure plus the difference between the next highest endoscopy procedure and the base endoscopy procedure. The base endoscopy procedure is included in the code for each of the multiple procedures. When two related endoscopies and an unrelated endoscopy are performed, the endoscopic payment rule stated above applies to the related endoscopies. Unrelated endoscopic procedures are treated as separate surgeries and paid as multiple surgeries pursuant to 130 CMR 433.452(C).

(E) Payment for Add-on Surgical Procedures. The Centers for Medicare & Medicaid Services (CMS) has identified certain procedures as add-on procedures that are always billed with another procedure. Add-on codes are identified in the CPT code book. By definition, these services do not stand alone and must be provided in conjunction with a primary surgical procedure or qualifying service. Both the service code for the primary procedure and add-on code are paid separately. The global surgery package provisions at 130 CMR 455.451 and 455.452 apply to the service code for the primary procedure.

(F) Payment for Bilateral Procedures. Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day. To receive payment, the surgeon must use the bilateral surgery modifier with the appropriate service code. The provider must not use the bilateral surgery modifier with service codes containing the terms "bilateral" or "unilateral or bilateral" in their definitions, since the terminology of the code identifies the service as one whose payment accounts for any additional work required for bilateral surgery.

(G) Surgical Assistants. Some surgical procedures require a primary surgeon and an assistant surgeon. To receive payment, the assistant surgeon must use the appropriate modifier. Surgical codes that accept the surgical assistant modifiers are indicated in The Centers for Medicare & Medicaid Services *Correct Coding Initiative Guide*. In addition, the MassHealth agency does not pay for a surgical assistant if

(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(H) or a two-surgeon modifier pursuant to 130 CMR 433.452(I);

(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency pays for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery; or

(3) the surgical procedure does not require the services of more than one surgeon.

(H) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other physician members of the surgical team.

(I) Two Surgeons (Co-Surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. Payment includes all surgical assistant fees.

(130 CMR 433.453 Reserved)

433.454: Anesthesia Services

(A) Payment.

(1) Payment Determination. The MassHealth agency pays an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) for anesthesia services as described in 101 CMR 316.00: *Surgery and Anesthesia*, and 130 CMR 433.454. Payment for anesthesia services is determined using a system of base anesthesia units and time anesthesia units.

(2) Base Anesthesia Units. Providers must report the administration of anesthesia on the claim by using the applicable five-digit anesthesia procedure code (00100-01999), and any applicable modifier. The anesthesia procedure code determines the number of base anesthesia units that correspond to the procedure. If a base anesthesia unit is not established for a service, the MassHealth agency pays using time anesthesia units only. When anesthesia is administered for multiple surgery procedures, only the base anesthesia units corresponding to the procedure with the largest number of units is used to determine payment. The number of base anesthesia units does not vary based on the type of anesthesia that is administered.

(3) Time Anesthesia Units.

(a) Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Payable anesthesia time ends when the patient may be safely placed under postoperative supervision.

(b) Reporting Time Anesthesia Units. A provider must report only payable time anesthesia units in the number of units field on the claim. The provider must not include base anesthesia units or units that exceed the criteria set forth in 130 CMR 433.454(A)(3)(a) in the number of units field. Time anesthesia units are measured in minutes. One unit equals one minute.

(4) Personally Performed Anesthesia Services. Anesthesia procedures that are personally performed alone by either an anesthesiologist, or a CRNA not employed by the facility in which the anesthesia services are provided, are payable by MassHealth. For a CRNA, personally performed anesthesia services are those that a CRNA performs alone without medical direction of an anesthesiologist. Payment for personally performed anesthesia services may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code. If a CRNA is employed by the facility in which the personally performed anesthesia services are provided, there is no separate payment for the CRNA's services. Refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

(5) Medical Direction and Medical Supervision. The MassHealth agency pays for medical direction as described in 101 CMR 316.00: *Surgery and Anesthesia* and 130 CMR 433.454(C). Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers. The MassHealth agency does not pay for medical supervision as further described in 130 CMR 433.454(D).

(B) Services Provided by a Certified Registered Nurse-Anesthetist (CRNA).

(1) General. 130 CMR 433.454 applies specifically to physicians and CRNAs. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians, also apply to CRNAs, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a CRNA or group practice for CRNA services when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(b) the CRNA or group practice is not an employee of the hospital or other facility in which the CRNA services were performed, or is not otherwise paid by the hospital or facility for the service;
(c) the CRNA participates in MassHealth pursuant to the requirements of 130 CMR 433.454(B)(3);
(d) the services of the CRNA are provided under the supervision of a physician such that the operating physician or an anesthesiologist is immediately available if needed; and
(e) for an out of state CRNA the requirements of 130 CMR 433.403(C) are met.

(3) CRNA Provider Eligibility. A CRNA may enroll in MassHealth as a provider. Any CRNA applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she
(a) is licensed to practice as a CRNA by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CRNA services are provided; and
(b) is a member of a group practice or is in a solo private practice.

(C) Medical Direction of Anesthesia Services. The MassHealth agency pays an anesthesiologist for medical direction of a CRNA as follows. The term medical direction is used in 130 CMR 433.454(C) for payment purposes only.
(1) Medical direction of anesthesia services occurs when an anesthesiologist is involved in no more than four concurrent anesthesia procedures and provides all of the following seven services to a patient:
(a) perform a pre-anesthetic examination and evaluation;
(b) prescribe the anesthesia plan;
(c) personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
(d) ensure that any procedures in the certified registered nurse anesthesia plan that he or she does not perform, are performed by a qualified anesthetist;
(e) monitor the course of anesthesia administration at frequent intervals;
(f) remain physically present and available for immediate diagnosis and treatment of emergencies; and
(g) provide the indicated post-anesthesia care.
(2) If one or more of the above services in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by the anesthesiologist, the service is not considered medical direction.
(3) Ordinarily, the anesthesiologist should not furnish additional services to other patients while concurrently directing the administration of anesthesia. The anesthesiologist can, however, provide any of the following services to other patients while medically directing the administration of anesthesia without affecting the anesthesiologist's ability to provide medical direction.
(a) addressing an emergency of short duration in the immediate area;
(b) administering an epidural or caudal anesthetic to ease labor pain;
(c) periodic rather than continuous monitoring of an obstetrical patient;
(d) receiving patients entering the operating suite for the next surgery;
(e) checking on or discharging patients from the post anesthesia care unit; and
(f) coordinating scheduling matters.
(4) Payment for medical direction of a CRNA may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code.

(a) If an anesthesiologist provides medical direction of a CRNA who participates in MassHealth in accordance with 130 CMR 433.454(B)(3) and is not employed by the facility in which the anesthesia services are performed, the anesthesiologist receives fifty percent (50%) of the fee and the CNRA receives fifty percent (50%) of the fee.
(b) If an anesthesiologist provides medical direction of a CRNA employed by a facility in which the anesthesia service is performed, the anesthesiologist receives fifty percent (50%) of the fee, but no separate payment is made for the CRNA's services.
(c) Anesthesiologists and CRNAs should refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

(D) Medical Supervision of Anesthesia Services. The MassHealth agency does not pay a physician for medical supervision of a CRNA. The term medical supervision is used in this section for payment purposes only.

(1) Medical supervision of anesthesia services occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures and when the anesthesiologist provides some, but not all of the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g).
(2) Medical supervision also occurs when the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by an anesthesiologist. This might occur in cases when the anesthesiologist:
(a) left the immediate area of the operating suite for more than a short duration;
(b) devote extensive time to an emergency case; or
(c) was otherwise not available to respond to the immediate needs of the surgical patients.

(E) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture as a substitute for conventional surgical anesthesia (see 130 CMR 433.440).

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 law.
(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) 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 CPA-2 form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, 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 433.472 Reserved)

433.473: Clinical Nurse Specialist (CNS) Services.

(A) General. 130 CMR 433.473 applies specifically to clinical nurse specialists. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician also apply to a clinical nurse specialist (CNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays a CNS or group practice for CNS services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);
(2) the CNS or group practice is not an employee or contractor of the hospital or other facility in which the CNS services were performed, or is not otherwise paid by the hospital or facility for their services;
(3) the CNS participates in MassHealth pursuant to the requirements of 130 CMR 433.473(C); and
(4) for an out of state CNS the requirements of 130 CMR 433.403(C) are met.

(C) Clinical Nurse Specialist Provider Eligibility. A CNS may enroll as a MassHealth provider. Any CNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency that he or she

(1) is licensed to practice as a CNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CNS services are provided; and
(2) is a member of a group practice or is in a solo private practice.

(D) Consultation Between A Clinical Nurse Specialist and Physician. The MassHealth agency does not pay for a consultation between a CNS and a physician as a separate service.

(130 CMR 433.474 through 433.484 Reserved)

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 118E, §§7 and 12.

This page is reserved.

601 Introduction

MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology (CPT) 2017* codebook for the service code descriptions 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.

Note: Rates paid by MassHealth for covered codes under this Subchapter 6 for drugs, vaccines, and immune globulins administered in a physician's office are as specified in 101 CMR 317.00: *Medicine*. Subject to any other applicable provision in 101 CMR 317.00, the payment rates for these MassHealth-covered codes for drugs, vaccines and immune globulins administered in the physician's office, are equal to the fees listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (see 101 CMR 317.03(1)(c)2 and 317.04(1)(a)). For applicable codes for drugs, vaccines, and immune globulins administered in a physician's office that are listed in Section 603 or 604, below, with "IC", payment set by IC will apply until such time as the code is listed and a rate set in the Quarterly ASP Medicare Part B Drug Pricing File, consistent with 101 CMR 317.04(1)(a).

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	15793	20936	22856	34839
11922	15824	20985	22858	36415
15776	15825	21121	22861	36416
15780	15826	21122	22864	36468
15781	15828	21123	32491	36591
15782	15829	21245	32850	36592
15783	15847	21246	32855	36598
15786	17340	21248	32856	38204
15787	17360	21249	33930	38207
15788	19355	22526	33933	38208
15789	19396	22527	33940	38209
15792	20930	22841	33944	38210

602 Nonpayable CPT Codes (cont.)

38211	58345	77417	80355	81235
38212	58350	77422	80356	81240
38213	58750	77423	80357	81241
38214	58752	77424	80358	81242
38215	58760	77425	80359	81243
41870	58970	77520	80360	81244
41872	58974	77522	80361	81245
43206	58976	77523	80362	81250
43252	59070	77525	80363	81251
43752	59072	77790	80364	81252
43842	59412	78267	80365	81253
43843	59897	78268	80366	81254
43845	61630	78351	80367	81255
44132	61635	80320	80368	81256
44381	61640	80321	80369	81257
44403	61641	80322	80370	81260
44404	61642	80323	80371	81261
44405	62287	80324	80372	81262
44406	63043	80325	80373	81263
44407	63044	80326	80374	81264
44408	65760	80327	80375	81265
44705	65765	80328	80376	81266
44715	65767	80329	80377	81267
45349	65771	80330	80500	81270
45350	69090	80331	80502	81275
45390	71552	80332	81200	81290
45393	72159	80333	81201	81291
45398	72198	80334	81202	81292
47133	73225	80335	81203	81293
47143	74263	80336	81205	81294
47144	75571	80337	81206	81295
47145	76140	80338	81207	81296
47383	76390	80339	81208	81297
48160	76496	80340	81209	81298
48550	76497	80341	81210	81299
48551	76498	80342	81213	81300
50300	77086	80343	81214	81301
50323	77336	80344	81216	81302
50325	77370	80345	81220	81303
54900	77371	80346	81221	81304
54901	77372	80347	81222	81310
55200	77373	80348	81223	81315
55300	77385	80349	81224	81316
55400	77386	80350	81225	81317
55870	77401	80351	81226	81318
58321	77402	80352	81227	81319
58322	77407	80353		81321
58323	77412	80354		81322

602 Nonpayable CPT Codes (cont.)

81323	82962	89254	90697	92564
81324	83987	89255	90698	92597
81325	84061	89257	90700	92605
81326	84145	89258	90702	92606
81330	84431	89259	90710	92613
81331	84830	89260	90723	92615
81332	86079	89261	90739	92617
81340	86305	89264	90743	92630
81341	86890	89268	90744	92633
81342	86891	89272	90748	93660
81350	86910	89280	90845	93668
81355	86911	89281	90863	93702
81370	86927	89290	90865	93770
81371	86930	89291	90875	93786
81372	86931	89321	90876	93895
81373	86932	89322	90880	94005
81374	86945	89325	90885	94015
81375	86950	89329	90889	94644
81376	86960	89330	90901	94645
81377	86965	89331	90911	95012
81378	86985	89335	90940	95052
81379	87150	89342	90989	95120
81380	87153	89343	90993	95125
81381	87493	89344	90997	95130
81382	88000	89346	90999	95131
81383	88005	89352	91112	95132
81400	88007	89353	91132	95133
81401	88012	89354	91133	95134
81402	88014	89356	92314	95824
81403	88016	89398	92315	95965
81404	88020	90281	92316	95966
81405	88025	90283	92317	95967
81406	88027	90284	92325	95992
81407	88028	90287	92352	96000
81408	88029	90384	92353	96001
81413	88036	90386	92354	96002
81414	88037	90389	92355	96003
81422	88040	90396	92358	96004
81500	88045	90586	92371	96040
81503	88099	90633	92531	96101
81506	88125	90634	92532	96102
81508	88333	90644	92533	96103
81509	88334	90647	92534	96105
81510	88738	90648	92548	96111
81511	88749	90653	92559	96116
81512	89250	90680	92560	96118
81599	89251	90685	92561	96119
82075	89253	90687	92562	96120

602 Nonpayable CPT Codes (cont.)

96125	98968	99174	99367	99486
96127	98969	99177	99368	99487
96150	99000	99190	99374	99489
96151	99001	99191	99375	99490
96152	99002	99192	99377	99495
96153	99024	99241	99378	99496
96154	99026	99242	99379	99497
96155	99027	99243	99380	99498
96376	99053	99244	99401	99500
96567	99056	99245	99402	99501
96902	99058	99251	99403	99502
96904	99060	99252	99404	99503
97014	99071	99253	99406	99504
97169	99075	99254	99408	99505
97170	99078	99255	99409	99506
97171	99080	99288	99411	99507
97172	99082	99315	99412	99509
97537	99090	99316	99429	99510
97545	99091	99339	99441	99511
97546	99100	99340	99442	99512
97755	99116	99354	99443	99601
98940	99135	99355	99444	99602
98941	99140	99356	99446	99605
98942	99151	99357	99447	99606
98943	99152	99358	99448	99607
98960	99153	99359	99449	
98961	99155	99360	99450	
98962	99156	99363	99455	
98966	99157	99364	99456	
98967	99172	99366	99485	

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

CD: MassHealth-specified clinical documentation must be submitted.

Covered for members birth to age 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.

Legend

Covered for members ≥ 19. This code is older; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age.

CPA-2: A completed Certification of Payable Abortion Form must be completed for all induced abortions, except medically induced abortions.

CS-18 or CS-21: A completed Sterilization Consent Form (CS-18 for members aged 18 through 20 years; CS-21 form for members aged 21 and older) must be submitted. See 130 CMR 433.456 through 433.458 for more information. payable only for members aged 19 or

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.

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

Service Code	Req. or Limit
01999	IC
11920	PA
11921	PA
11950	CD (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
11951	CD (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
11952	CD (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
11954	CD (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
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
15836	PA
15837	PA
15838	PA
15839	PA
15876	CD; IC (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
15877	CD; IC (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
15878	CD; IC (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
15879	CD; IC (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)
15999	IC
17380	PA (covered in preparation for gender affirming surgery only)
17999	PA; 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
19328	PA
19340	PA
19350	PA
19499	IC
20999	IC
21088	IC
21089	IC
21137	PA
21138	PA
21139	PA
21146	PA
21147	PA
21150	PA
21151	PA
21154	PA
21155	PA
21159	PA
21160	PA
21172	PA
21175	PA
21188	PA
21193	PA
21194	PA
21195	PA
21196	PA

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

Service Code	Req. or Limit	Service Code	Req. or Limit
21198	PA	30430	PA
21199	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
21743	IC	34842	IC
21899	IC	34843	IC
22857	PA	34844	IC
22862	PA	34845	IC
22865	PA	34846	IC
22899	IC	34847	IC
22999	IC	34848	IC
23929	IC	36299	IC
24940	IC	36470	PA
24999	IC	36471	PA
25999	IC	37195	IC
26989	IC	37501	IC
27299	IC	37799	IC
27599	IC	38129	IC
27899	IC	38230	PA
28890	PA	38240	PA
28899	IC	38241	PA
29799	IC	38242	PA
29800	PA	38589	IC
29804	PA	38999	IC
29999	IC	39499	IC
30400	PA	39599	IC
30410	PA	40799	IC
30420	PA	40840	PA

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

Service Code	Req. or Limit	Service Code	Req. or Limit
40842	PA	44799	IC
40843	PA	44899	IC
40844	PA	44979	IC
40845	PA	45399	IC
40899	IC	45499	IC
41599	IC	45999	IC
41820	PA; IC	46999	IC
41821	IC	47135	PA
41850	IC	47379	IC
41899	IC	47399	IC
42280	PA	47579	IC
42281	PA	47999	IC
42299	IC	48554	PA
42699	IC	48999	IC
42999	IC	49329	IC
43289	IC	49659	IC
43496	IC	49906	IC
43499	IC	49999	IC
43644	PA	50549	IC
43645	PA	50949	IC
43647	PA; IC	51925	HI-1
43648	IC	51999	IC
43659	IC	53430	PA (for gender dysphoria-
43770	PA		related services only)
43771	PA	53899	IC
43772	PA	54125	PA (for gender dysphoria-
43773	PA		related services only)
43774	PA	54400	PA
43775	PA	54401	PA
43846	PA	54405	PA
43847	PA	54440	IC
43848	PA	54520	PA (for gender dysphoria-
43881	PA; IC		related services only)
43882	IC	54660	PA (for gender dysphoria-
43886	PA		related services only)
43887	PA	54690	PA (for gender dysphoria-
43888	PA		related services only)
43999	IC	54699	IC
44133	IC	55175	PA (for gender dysphoria-
44135	PA; IC		related services only)
44136	PA; IC	55180	PA (for gender dysphoria-
44137	PA; IC		related services only)
44238	IC	55250	CS-18 or CS-21

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

Service Code	Req. or Limit
55450	CS-18 or CS-21
55559	IC
55899	IC; PA (for gender dysphoria-related services only)
55970	PA, IC
55980	PA, IC
56620	PA (for gender dysphoria-related services only)
56625	PA (for gender dysphoria-related services only)
56800	PA
56805	IC
57110	PA (for gender dysphoria-related services only)
57291	PA (for gender dysphoria-related services only)
57292	PA (for gender dysphoria-related services only)
57335	IC
58150	HI-1; PA (for gender dysphoria-related services only)
58152	HI-1
58180	HI-1; PA (for gender dysphoria-related services only)
58200	HI-1
58210	HI-1
58240	HI-1
58260	HI-1; PA (for gender dysphoria-related services only)
58262	HI-1; PA (for gender dysphoria-related services only)
58263	HI-1
58267	HI-1
58270	HI-1
58275	HI-1
58280	HI-1
58285	HI-1
58290	HI-1; PA (for gender dysphoria-related services only)
58291	HI-1; PA (for gender dysphoria-related services only)
58292	HI-1
58293	HI-1
58294	HI-1
58541	HI-1; PA (for gender dysphoria-related services only)
58542	HI-1; PA (for gender dysphoria-related services only)
58543	HI-1; PA (for gender dysphoria-related services only)
58544	HI-1; PA (for gender dysphoria-related services only)
58548	HI-1
58550	HI-1; PA (for gender dysphoria-related services only)
58552	HI-1; PA (for gender dysphoria-related services only)
58553	HI-1; PA (for gender dysphoria-related services only)
58554	HI-1; PA (for gender dysphoria-related services only)
58565	CS-18 or CS-21
58570	HI-1; PA (for gender dysphoria-related services only)
58571	HI-1; PA (for gender dysphoria-related services only)
58572	HI-1; PA (for gender dysphoria-related services only)

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

Service Code	Req. or Limit	Service Code	Req. or Limit
58573	HI-1; PA (for gender dysphoria-related services only)	67399	IC
		67599	IC
		67900	PA
58578	IC	67901	PA
58579	IC	67902	PA
58600	CS-18 or CS-21	67903	PA
58605	CS-18 or CS-21	67904	PA
58611	CS-18 or CS-21	67906	PA
58615	CS-18 or CS-21	67908	PA
58661	CS-18* or CS-21*; PA (for gender dysphoria-related services only)	67999	IC
		68399	IC
		68899	IC
58670	CS-18 or CS-21	69300	PA
58671	CS-18 or CS-21	69399	IC
58679	IC	69710	IC
58720	CS-18* or CS-21*; PA (for gender dysphoria-related services only)	69799	IC
		69930	PA
		69949	IC
58951	HI-1	69979	IC
58956	HI-1	74261	PA
58999	IC; PA (for gender dysphoria-related services only)	74262	PA
		76499	IC
59135	HI-1	76999	IC
59525	HI-1	77058	PA
59840	CPA-2	77059	PA
59841	CPA-2	77061	IC
59850	CPA-2	77062	IC
59851	CPA-2	77299	IC
59852	CPA-2	77387	IC
59855	CPA-2	77399	IC
59856	CPA-2	77499	IC
59857	CPA-2	77799	IC
59898	IC	78099	IC
59899	IC	78199	IC
60659	IC	78299	IC
60699	IC	78399	IC
64650	PA	78499	IC
64653	PA	78599	IC
64999	IC	78699	IC
65757	IC	78799	IC
65785	PA	78999	IC
66999	IC	79999	IC
67299	IC	81099	IC

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

Service Code	Req. or Limit
81211	PA
81212	PA
81215	PA
81217	PA
81228	IC
81229	IC
81420	PA; IC
81479	IC
81507	PA
81519	PA
84999	IC
85999	IC
86849	IC
86999	IC
87999	PA; IC
88199	IC
88299	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
90620	IC
90621	IC
90625	IC
90630	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90632	Covered for adults ≥ 19; available free of charge through the Massachusetts Immunization Program for Immunization Program for children younger than 19 years of age
90636	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90649	Covered for members aged 19 to 26 years; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90650	Covered for female members aged 19 to 26 years; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90651	IC; Covered for female members aged 19 to 26 years; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90654	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90655	IC
90657	IC
90658	IC
90660	IC
90661	IC
90664	IC
90666	IC
90667	IC
90668	IC

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

Service Code	Req. or Limit
90670	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90672	Covered for members > 19 < 49; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90673	Covered for members Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90676	IC
90681	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90682	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90686	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90688	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90690	IC
90696	IC
90707	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90713	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90715	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90716	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90717	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90732	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90733	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age

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

Service Code	Req. or Limit
90734	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90736	IC; PA is required for members less than age 50
90738	IC
90749	IC
90750	IC
90867	IC
90868	IC
90899	IC
90935	For hospitalized member only; not for chronic maintenance
90937	For hospitalized member only; not for chronic maintenance
90945	For hospitalized member only; not for chronic maintenance
90947	For hospitalized member only; not for chronic maintenance
90952	IC
90953	IC
91110	PA
91111	PA
91299	IC
92065	PA
92250	PA
92310	PA; includes supply of lenses
92311	PA; includes supply of lenses
92312	PA; includes supply of lenses
92313	PA; includes supply of lenses
92326	PA
92499	IC
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
92610	PA for ST >35
92700	IC
92921	IC
92925	IC
92929	IC
92934	IC
92938	IC
92944	IC
93229	IC
93299	IC
93745	IC
93799	IC
93998	IC
94669	PA
94772	IC
94774	IC
94775	IC
94776	IC
94777	IC
94799	IC
95199	IC
95803	IC
95999	IC
96377	IC
96379	IC
96549	IC
96931	IC
96932	IC
96933	IC
96934	IC
96935	IC
96936	IC
96999	IC
97010	PA for PT >20
97012	PA for PT >20
97016	PA for PT >20
97018	PA for PT >20
97022	PA for PT >20
97024	PA for PT >20
97026	PA for PT >20
97028	PA for PT >20

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

Service Code	Req. or Limit
97032	PA for PT >20
97033	PA for PT >20
97034	PA for PT >20
97035	PA for PT >20
97036	PA for PT >20
97039	PA for PT >20; IC
97110	PA for PT >20
97112	PA for PT >20
97113	PA for PT >20
97116	PA for PT >20
97124	PA for PT >20
97139	PA for PT >20; IC
97140	PA for PT >20
97150	PA for PT >20
97161	PA for PT >20
97162	PA for PT >20
97163	PA for PT >20
97164	PA for PT >20
97165	PA for PT >20
97166	PA for PT >20
97167	PA for PT >20
97168	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
97607	IC
97608	IC
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
98929	PA for OMT >20
99050	Urgent care only
99051	Urgent care only
99070	IC; excluding family planning supplies, such as trays, used in used in the collection of specimens
99188	Once per three-month period
99195	For hematologic disorders only
99199	IC
99499	IC
99600	IC
96110	Developmental screening, with interpretation and report, per standardized instrument form. Covered for members birth to age 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.

604 Payable HCPCS Level II Service Codes

This section lists Level II HCPCS codes that are payable under MassHealth. For more detailed descriptions when billing for Level II HCPCS codes provided to MassHealth members, refer to the Centers for Medicare & Medicaid Services website at www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

Service	Code
A4261	IC
A4266	
A4267	
A4268	
A4269	
A4641	IC
A4648	IC
A9500	IC
A9502	IC
A9503	IC
A9505	IC
A9512	IC
A9537	IC
A9576	
A9577	
A9578	
A9579	
A9581	
G0027	
G0105	
G0108	
G0109	
G0121	
G0270	
G0271	
G0279	
G0297	
G0455	IC
G0480	
G0481	
G0482	
G0483	
J0129	PA
J0131	IC
J0135	PA; IC
J0153	
J0171	
J0178	
J0202	PA
J0215	PA; IC
J0221	PA
J0256	
J0257	
J0285	
J0287	
J0289	
J0290	
J0295	
J0348	
J0364	IC
J0400	IC
J0401	
J0456	
J0461	
J0470	
J0475	
J0476	
J0485	PA
J0490	PA
J0558	
J0561	
J0570	PA
J0571	IC; PA
J0572	IC
J0573	IC
J0574	IC
J0575	IC
J0585	PA
J0586	PA
J0587	PA
J0588	PA
J0592	
J0594	
J0596	PA ; IC
J0598	PA
J0636	
J0637	
J0638	PA
J0640	
J0641	
J0670	
J0690	
J0692	
J0694	
J0696	
J0697	
J0702	
J0712	
J0713	
J0715	PA; IC
J0716	IC
J0717	PA
J0720	
J0740	
J0743	
J0770	
J0775	PA
J0780	
J0833	IC
J0834	
J0840	
J0850	
J0878	
J0881	PA
J0882	PA
J0883	IC
J0884	IC
J0885	PA
J0887	PA
J0888	PA
J0890	PA; IC
J0894	
J0895	
J0897	PA

604 Payable HCPCS Level II Service Codes (cont)

Service Code		Service Code		Service Code	
J1000		J1626		J2270	
J1020		J1630		J2274	
J1030		J1642		J2278	
J1040		J1644		J2300	
J1050		J1645		J2310	
J1071	PA	J1650		J2315	
J1094	IC	J1652		J2323	
J1100		J1655	IC	J2353	
J1130	PA; IC	J1670		J2354	
J1160		J1700	IC	J2355	PA
J1170		J1710	IC	J2357	PA
J1190		J1720		J2358	PA
J1200		J1725	PA; IC	J2400	
J1212		J1740	PA	J2405	
J1240		J1743		J2426	PA
J1260	IC	J1744	PA ; IC	J2430	
J1290		J1745	PA	J2440	IC
J1300		J1750		J2460	IC
J1320	IC	J1756	PA	J2469	
J1322	PA ; IC	J1786	PA	J2502	PA; IC
J1438	PA	J1790	IC	J2503	
J1439	PA	J1800		J2504	
J1442	PA	J1815		J2505	
J1447		J1826	IC	J2507	PA; IC
J1453		J1830	IC	J2510	
J1455	IC	J1840	IC	J2515	
J1458		J1850	IC	J2540	
J1459		J1885		J2543	
J1460		J1890	IC	J2545	
J1556		J1930		J2550	
J1557	PA ; IC	J1931		J2560	
J1559	PA	J1942	PA	J2562	
J1561	PA	J1950	PA	J2675	
J1562	PA ; IC	J1956		J2680	
J1566	PA	J1990	IC	J2700	
J1568	PA	J2060		J2704	
J1569	PA	J2150		J2760	IC
J1571		J2170	IC	J2778	
J1572		J2175		J2785	
J1573	IC	J2182	PA; IC	J2786	PA; IC
J1575		J2212	IC; PA	J2788	
J1580		J2248		J2790	
J1599	PA; IC	J2250		J2791	
J1602	PA	J2265	IC	J2792	

604 Payable HCPCS Level II Service Codes (cont)

Service Code					
J2793	PA ; IC	J3475		J7509	
J2794		J3486		J7510	
J2795		J3489	PA	J7511	
J2796	PA	J3490	IC	J7512	
J2820		J3490-FP	IC	J7515	
J2840	PA; IC	J3590	IC	J7517	
J2910	IC	J7030		J7518	
J2916		J7040		J7520	
J2920		J7050		J7527	
J2930		J7060		J7599	IC
J2940	PA ; IC	J7070		J7608	
J2941	PA ; IC	J7120		J7614	PA
J2997		J7131	IC	J7620	
J3000		J7297	IC	J7626	
J3010		J7298	IC	J7633	IC
J3030	IC	J7301	IC	J7639	
J3060	PA	J7303	IC	J7644	
J3095	PA	J7304	IC	J7665	IC
J3110	PA ; IC	J7307	IC	J7669	IC
J3121	PA	J7309	IC	J7676	IC
J3145	PA; IC	J7310	IC	J7682	
J3230		J7311	IC	J7686	PA
J3240		J7312	IC	J7699	IC
J3243		J7313		J7799	IC
J3250		J7315	IC	J7999	IC
J3262	PA	J7316		J8562	IC
J3285		J7320	PA	J8655	
J3300		J7321	PA	J8670	PA; IC
J3301		J7322	PA; IC	J9000	
J3302	IC	J7323	PA	J9015	IC
J3303		J7324	PA	J9017	
J3315		J7325	PA	J9019	PA
J3357	PA	J7326	PA	J9020	IC
J3360		J7327	PA	J9025	
J3370		J7328	PA; IC	J9031	
J3385	PA	J7336	PA	J9033	
J3396		J7340	IC	J9034	
J3410		J7342	IC	J9035	
J3411		J7500		J9040	
J3430		J7502		J9041	
J3465		J7503		J9042	PA
J3471		J7504		J9043	PA; IC
J3472	IC	J7507		J9045	
J3473		J7508		J9047	PA

604 Payable HCPCS Level II Service Codes (cont)

Service Code					
J9050		J9262	PA ; IC	Q2043	PA
J9055		J9263		Q2049	IC
J9060		J9264		Q2050	
J9065		J9266		Q4074	
J9070		J9267		Q4081	
J9098		J9268		Q4101	
J9100		J9280		Q4102	
J9120		J9293		Q4103	IC
J9130		J9295	PA	Q4104	IC
J9145	PA	J9300	IC	Q4106	
J9155	PA	J9301	PA	Q4107	
J9160	IC	J9302	PA ; IC	Q4108	IC
J9171		J9303		Q4110	IC
J9176	PA	J9305		Q4121	
J9178		J9306	PA	Q4131	
J9179	PA	J9307		Q4132	
J9181		J9310	PA	Q4133	
J9185		J9315	PA	Q4161	IC
J9190		J9320		Q4162	IC
J9200		J9325	PA	Q4163	IC
J9201		J9328		Q4164	IC
J9202	PA	J9330		Q4165	IC
J9205	PA	J9340	IC	Q5101	
J9206		J9351		Q9950	
J9207		J9354	PA	Q9980	PA; IC
J9208		J9355		S0020	IC
J9209		J9357		S0021	IC
J9211		J9360		S0023	IC
J9212	IC	J9370		S0077	IC
J9213		J9371	PA	S0190	IC
J9214		J9390		S0191	IC
J9215	IC	J9395	PA	S0199	
J9216	IC	J9400	PA	S0302	
J9217	PA	J9999	IC	S2260 (CPA-2); IC	
J9218	PA	Q0138		S3005	
J9219	PA ; IC	Q0139		S4989	IC
J9225		Q0162		S4993	
J9226		Q2009	IC	T1023	
J9228	IC	Q2017	IC	V2600	PA; IC
J9230		Q2035		V2610	PA; IC
J9250		Q2036	IC	V2615	PA; IC
J9260		Q2037		V2799	PA; IC
J9261	PA	Q2038	IC		

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth. See the MassHealth Billing Guide for Paper Claim Submitters for billing instructions on the use of modifiers.

Modifier	Modifier Description
22	Increased Procedural Services
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
52	Reduced services
53	Discontinued service
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
AA	Anesthesia services performed personally by an anesthesiologist. (This allows payment of 100% of the Total Anesthesia Fee for the anesthesiologist's services)
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

605 Modifiers (cont.)

Modifier	Modifier Description
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
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LT	Left side (used to identify procedures performed on the left side of the body)
LM	Left main coronary artery
QK	Medical direction by a physician of two, three or four concurrent anesthesia procedures. (Use to indicate physician medical direction of multiple CRNAs. This allows payment of 50% of the Total Anesthesia Fee for the physician's services).
QY	Medical direction of one CRNA by a physician. (Use to indicate physician medical direction of one CRNA. This allows payment of 50% of the Total Anesthesia Fee for the physician's services).
QX	CRNA anesthesia services with medical direction by a physician. (Use to indicate CRNA anesthesia services with medical direction by a physician. This allows payment of 50% of the Total Anesthesia Fee for the CRNA's services. Not for use if CRNA is employed by the facility in which the anesthesia services were performed).
QZ	CRNA anesthesia services without medical direction by a physician. (This allows payment of 100% of the Total Anesthesia Fee for the CRNA's services. Not for use if CRNA is employed by the facility in which the anesthesia services were performed.)
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 service codes billed by a physician that were performed by a certified nurse practitioner employed by the physician (the physician employer must be practicing as an individual and not practicing as a professional corporation or as a member of a group practice.) A certified nurse practitioner billing under his/her own individual provider number, or a group practice, should not use this modifier.)
SL	State supplied vaccine (This modifier should only be applied to codes 90460, 90461, 90471, 90472, 90473, and 90474 to identify administration of vaccines provided at no cost by the Massachusetts Department of Public Health for individuals aged 18 years and younger, including those administered under the Vaccine for Children Program (VFC).)
T1	Left foot, second digit

605 Modifiers (cont.)

Modifier	Modifier Description
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. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Modifiers for Tobacco-Cessation Services

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

Modifier	Modifier Description
HQ	Group counseling, at least 60–90 minutes in duration, provided by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, psychiatric clinical nurse specialist or certified nurse midwife.
TD	Individual counseling provided by a registered nurse (RN) under the supervision of a physician.
TF	Individual counseling, intensive (intake/assessment counseling, at least 45 minutes in duration) provided by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, psychiatric clinical nurse specialist or certified nurse midwife

605 Modifiers (cont.)

Modifier	Modifier Description
U1	Individual counseling services provided by a tobacco-cessation counselor under the supervision of a physician
U2	Individual counseling; intensive (intake/assessment counseling, at least 45 minutes in duration), provided by a 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 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, certified nurse midwife, certified nurse practitioner or physician assistant.

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, certified nurse midwife, certified nurse practitioner or physician assistant.

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 certified 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 certified nurse practitioner employed by a physician.

UD Covered for members birth to 6 months for the administration and scoring of the Edinburgh Postnatal Depression Scale. UD must be used together with one of the above modifiers, U1, U2, U5 or U6.

Modifiers for Administration of MassHealth-Approved Screening Tools

Service Code S3005, used for the performance measurement and evaluation of patient self-assessment and depression, must be accompanied by one of the modifiers below to indicate whether a behavioral health need was identified.

Modifier	Modifier Description
U1	Perinatal Care Provider - Positive Screen: completed prenatal or postpartum depression screening and behavioral health need identified.
U2	Perinatal Care Provider - Negative Screen: completed prenatal or postpartum depression screening with no behavioral health need identified.

Please refer to the Massachusetts Department of Public Health's (DPH) postpartum depression (PPD) screening-tool grid for any revisions to the list of MassHealth-approved screening tools at www.mass.gov/eohhs/gov/departments/dph/programs/family-health/postpartum-depression/postpartum-depression-tools.html.

Modifier for Child and Adolescent Needs and Strengths (CANS)

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

Modifiers for Provider Preventable Conditions That Are National Coverage Determinations

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

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