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

MassHealth
Transmittal Letter PHY-155
April 2018

TO: Physicians Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: Physician Manual (2018 HCPCS Code Revisions; New Prior Authorization Requirements for Knee Arthroscopy and Knee Arthroplasty)

Summary

This letter transmits revisions to Subchapter 6 of the *Physician Manual***,** and also transmits a new requirement for prior authorization for the provision of knee arthroscopy and knee arthroplasty services, as specified below.

2018 HCPCS / CPT Updates

The Centers for Medicare & Medicaid Services (CMS) has revised the Healthcare Common Procedure Coding System (HCPCS) codes for 2018. MassHealth has updated Subchapter 6 of the *Physician Manual* to incorporate those 2018 HCPCS/CPT service code updates, as applicable. Providers must use the new codes to obtain reimbursement **for dates of service on or after January 1, 2018.** MassHealth has also updated Subchapter 6 to reflect changes to special requirements or limitations for applicable codes.

Prior Authorization for Knee Arthroscopy and Knee Arthroplasty

Effective June 1, 2018, physicians must obtain prior authorization (PA) from MassHealth for knee arthroscopy and knee arthroplasty services. This policy change will apply to the following Current Procedural Terminology (CPT) codes: 27445, 27446, 27447, 27486, 27487, 27488, 29870, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, and 29889. MassHealth has updated Subchapter 6 of the *Physician's Manual* to indicate that PA will be required for these services effective June 1.

A PA request for these services must be accompanied by clinical documentation to support medical necessity. MassHealth *Guidelines for Medical Necessity Determination for Knee Arthroscopy* and *Guidelines for Medical Necessity Determination for Knee Arthroplasty* are being updated and scheduled for providers to use this spring (www.mass.gov/masshealth/guidelines).

In the meantime, effective June 1, 2018, providers must submit the following clinical documentation with their PA requests for these knee arthroscopy and knee arthroplasty services:

1) The primary diagnosis name(s) and the ICD-CM code(s) for the condition requiring knee arthroscopy/arthroplasty;

Prior authorization and clinical documentation *(cont.)*

2) The secondary diagnosis name(s) and ICD-CM code(s) pertinent to any comorbid conditions, if present;
3) A description of the specific arthroscopic/arthroplasty procedure and appropriate CPT code(s) for the procedure being requested;
4) The most recent medical evaluation, including a summary of the medical history and the most recent physical exam with emphasis on the orthopedic knee examination and testing specific to the patient's condition;
5) Results of radiology studies (routine x-rays, MRI, CT, etc.) and other tests relevant to the condition for which knee arthroscopy/arthroplasty is being requested;
6) A summary of the nonoperative, conservative treatment(s) that have been tried and have been unsuccessful in managing the patient's condition;
7) Any risk factors and/or comorbid conditions; and
8) Other pertinent information that MassHealth may request.

MassHealth reviews requests for PA on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

MassHealth Website

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

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Questions

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

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

Physician Manual

Pages 6-1 through 6-24

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

Physician Manual

Pages 6-1 through 6-24 — transmitted by Transmittal Letter PHY-154

601 Introduction

MassHealth providers must refer to the American Medical Association's Current Procedural Terminology (CPT) 2018 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 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 Section 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	15788	15847	21122	22856
11922	15789	17340	21123	22858
15776	15792	17360	21245	22861
15780	15793	19355	21246	22864
15781	15824	19396	21248	32491
15782	15825	20930	21249	32850
15783	15826	20936	22526	32855
15786	15828	20985	22527	32856
15787	15829	21121	22841	33930

602 Nonpayable CPT Codes (cont.)

33933	50300	77371	80350	81227
33940	50323	77372	80351	81235
33944	50325	77373	80352	81240
34839	54900	77385	80353	81241
36415	54901	77386	80354	81242
36416	55200	77401	80355	81243
36468	55300	77402	80356	81244
36591	55400	77407	80357	81245
36592	55870	77412	80358	81250
36598	58321	77417	80359	81251
38204	58322	77423	80360	81252
38207	58323	77424	80361	81253
38208	58345	77425	80362	81254
38209	58350	77520	80363	81255
38210	58750	77522	80364	81256
38211	58752	77523	80365	81257
38212	58760	77525	80366	81260
38213	58970	77790	80367	81261
38214	58974	78267	80368	81262
38215	58976	78268	80369	81263
41870	59070	78351	80370	81264
41872	59072	80320	80371	81265
43206	59412	80321	80372	81266
43252	59897	80322	80373	81267
43752	61630	80323	80374	81270
43842	61635	80324	80375	81275
43843	61640	80325	80376	81290
43845	61641	80326	80377	81291
44132	61642	80327	80500	81292
44381	62287	80328	80502	81293
44403	63043	80329	81200	81294
44404	63044	80330	81201	81295
44405	65760	80331	81202	81296
44406	65765	80332	81203	81297
44407	65767	80333	81205	81298
44408	65771	80334	81206	81299
44705	69090	80335	81207	81300
44715	71552	80336	81208	81301
45349	72159	80337	81209	81302
45350	72198	80338	81210	81303
45390	73225	80339	81213	81304
45393	74263	80340	81214	81310
45398	75571	80341	81216	81315
47133	76140	80342	81220	81316
47143	76390	80343	81221	81317
47144	76496	80344	81222	81318
47145	76497	80345	81223	81319
47383	76498	80346	81224	81321
48160	77086	80347	81225	81322
48550	77336	80348	81226	81323
48551	77370	80349		81324

602 Nonpayable CPT Codes (cont.)

81325	86079	89272	90885	95012
81326	86305	89280	90889	95052
81330	86890	89281	90901	95120
81331	86891	89290	90911	95125
81332	86910	89291	90940	95130
81340	86911	89321	90989	95131
81341	86927	89322	90993	95132
81342	86930	89325	90997	95133
81350	86931	89329	90999	95134
81355	86932	89330	91112	95824
81370	86945	89331	91132	95965
81371	86950	89335	91133	95966
81372	86960	89342	92314	95967
81373	86965	89343	92315	95992
81374	86985	89344	92316	96000
81375	87150	89346	92317	96001
81376	87153	89352	92325	96002
81377	87493	89353	92352	96003
81378	88000	89354	92353	96004
81379	88005	89356	92354	96040
81380	88007	89398	92355	96101
81381	88012	90586	92358	96102
81382	88014	90587	92371	96103
81383	88016	90634	92531	96105
81400	88020	90644	92532	96111
81401	88025	90647	92533	96116
81402	88027	90648	92534	96118
81403	88028	90649	92548	96119
81404	88029	90650	92559	96120
81405	88036	90653	92560	96125
81406	88037	90655	92561	96127
81407	88040	90657	92562	96150
81408	88045	90672	92564	96151
81413	88099	90680	92597	96152
81414	88125	90681	92605	96153
81422	88333	90685	92606	96154
81500	88334	90687	92613	96155
81503	88738	90697	92615	96160
81506	88749	90698	92617	96161
81508	89250	90700	92630	96376
81509	89251	90702	92633	96567
81510	89253	90723	93660	96570
81511	89254	90743	93668	96571
81512	89255	90744	93702	96573
81599	89257	90748	93770	96574
82075	89258	90845	93786	96902
82962	89259	90863	93895	96904
83987	89260	90865	94005	97014
84145	89261	90875	94015	97169
84431	89264	90876	94644	97170
84830	89268	90880	94645	97171

602 Nonpayable CPT Codes (cont.)

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

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.

Covered for members ≥ 19. This code is payable only for members age 19 or 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.

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: Service requires prior authorization. See 130 CMR 433.408 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.

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

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

Service Code	Req. or Limit
21193	PA
21194	PA
21195	PA
21196	PA
21198	PA
21199	PA
21206	PA
21208	PA
21209	PA
21210	PA
21215	PA
21230	PA
21235	PA
21240	PA
21242	PA
21243	PA
21244	PA
21247	PA
21255	PA
21256	PA
21299	PA; IC
21499	IC
21742	IC
21743	IC
21899	IC
22857	PA
22862	PA
22865	PA
22899	IC
22999	IC
23929	IC
24940	IC
24999	IC
25999	IC
26989	IC
27299	IC
27445	PA[1]
27446	PA[1]
27447	PA[1]
27486	PA[1]
27487	PA[1]
27488	PA[1]
27599	IC
27899	IC
28890	PA
28899	IC
29799	IC
29800	PA
29804	PA
29870	PA[1]
29873	PA[1]
29874	PA[1]
29875	PA[1]
29876	PA[1]
29877	PA[1]
29879	PA[1]
29880	PA[1]
29881	PA[1]
29882	PA[1]
29883	PA[1]
29884	PA[1]
29885	PA[1]
29886	PA[1]
29887	PA[1]
29888	PA[1]
29889	PA[1]
29999	IC
30400	PA
30410	PA
30420	PA
30430	PA
30435	PA
30450	PA
30999	IC
31299	IC
31599	IC
31899	IC
32851	PA
32852	PA
32853	PA
32854	PA
32999	IC
33935	PA
33945	PA
33981	IC
33982	IC
33983	IC
33999	IC
34841	IC
34842	IC

[1] Effective date for this prior-authorization requirement is 06/01/18.

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

Service Code	Req. or Limit
34843	IC
34844	IC
34845	IC
34846	IC
34847	IC
34848	IC
36299	IC
36470	PA
36471	PA
37195	IC
37216	IC
37501	IC
37799	IC
38129	IC
38230	PA
38240	PA
38241	PA
38242	PA
38589	IC
38999	IC
39499	IC
39599	IC
40799	IC
40840	PA
40842	PA
40843	PA
40844	PA
40845	PA
40899	IC
41599	IC
41820	PA; IC
41821	IC
41850	IC
41899	IC
42280	PA
42281	PA
42299	IC
42699	IC
42999	IC
43289	IC
43496	IC
43499	IC
43644	PA
43645	PA
43647	PA; IC
43648	IC
43659	IC
43770	PA
43771	PA
43772	PA
43773	PA
43774	PA
43775	PA
43846	PA
43847	PA
43848	PA
43881	PA; IC
43882	IC
43886	PA
43887	PA
43888	PA
43999	IC
44135	PA; IC
44136	PA; IC
44137	PA; IC
44238	IC
44799	IC
44899	IC
44979	IC
45399	IC
45499	IC
45999	IC
46999	IC
47135	PA
47379	IC
47399	IC
47579	IC
47999	IC
48554	PA
48999	IC
49329	IC
49659	IC
49906	IC
49999	IC
50549	IC
50949	IC
51925	HI-1
51999	IC
53430	PA (for gender dysphoria-related services only)

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

Service Code	Req. or Limit
53899	IC
54125	PA (for gender dysphoria-related services only)
54400	PA
54401	PA
54405	PA
54440	IC
54520	PA (for gender dysphoria-related services only)
54660	PA (for gender dysphoria-related services only)
54690	PA (for gender dysphoria-related services only)
54699	IC
55175	PA (for gender dysphoria-related services only)
55180	PA (for gender dysphoria-related services only)
55250	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

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

Service Code	Req. or Limit
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)
58573	HI-1; PA (for gender dysphoria-related services only)
58575	HI-1; PA (for gender dysphoria-related services only)
58578	IC
58579	IC
58600	CS-18 or CS-21
58605	CS-18 or CS-21
58611	CS-18 or CS-21
58615	CS-18 or CS-21
58661	CS-18* or CS-21*; PA (for gender dysphoria-related services only)
58670	CS-18 or CS-21
58671	CS-18 or CS-21
58679	IC
58720	CS-18* or CS-21*; PA (for gender dysphoria-related services only)
58951	HI-1
58956	HI-1
58999	IC; PA (for gender dysphoria-related services only)
59525	HI-1
59135	HI-1
59840	CPA-2
59841	CPA-2
59850	CPA-2
59851	CPA-2
59852	CPA-2
59855	CPA-2
59856	CPA-2
59857	CPA-2
59898	IC
59899	IC
60659	IC
60699	IC
64650	PA
62380	IC
64653	PA
64999	IC
65757	IC
65785	PA
66999	IC
67299	IC
67399	IC
67599	IC
67900	PA
67901	PA
67902	PA
67903	PA
67904	PA
67906	PA
67908	PA
67999	IC
68399	IC
68899	IC
69300	PA
69399	IC
69710	IC
69799	IC
69930	PA
69949	IC
69979	IC
74261	PA
74262	PA
76499	IC
76999	IC
77058	PA
77059	PA

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

Service Code	Req. or Limit
77061	IC
77062	IC
77299	IC
77387	IC
77399	IC
77499	IC
77799	IC
78099	IC
78199	IC
78299	IC
78399	IC
78499	IC
78599	IC
78699	IC
78799	IC
78999	IC
79999	IC
81099	IC
81162	PA
81211	PA
81212	PA
81215	PA
81217	PA
81228	PA; IC
81229	PA; IC
81420	PA; IC
81479	IC
81507	PA; IC
81519	PA; IC
84999	IC
88199	IC
85999	IC
86849	IC
86999	IC
87999	PA; IC
88299	IC
88399	IC
89240	IC
90281	IC
90283	IC
90284	IC
90287	IC
90288	IC
90296	IC
90378	PA; IC
90384	IC
90385	IC
90386	IC
90389	IC
90393	PA; IC
90396	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 children younger than 19 years of age
90633	IC; Covered for members ≥ 19; available free of charge through the Massachusetts 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
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

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

Service Code	Req. or Limit
	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
90658	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90660	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90661	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90664	IC
90666	IC
90667	IC
90668	IC
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 ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90676	IC
90682	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
90710	IC; Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90713	IC; 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

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

Service Code	Req. or Limit
	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
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 younger than age 50
90738	IC
90739	IC; Covered for members ≥19
90749	IC
90750	IC; PA required for members younger than age 50
90756	Covered for members ≥ 19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90867	IC
90868	PA for >30 sessions per course treatment[1]; IC
90869	IC
90899	IC
90935	For hospitalized members only; not for chronic maintenance
90937	For hospitalized members only; not for chronic maintenance
90945	For hospitalized members only; not for chronic maintenance
90947	For hospitalized members only; not for chronic maintenance
90952	IC
90953	IC
91110	PA
91111	PA
91299	IC
92065	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
92558	IC
92610	PA for ST >35
92700	IC
92921	IC
92925	IC
92929	IC
92934	IC

[1] Effective date for this prior-authorization requirement is 06/01/18.

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

Service Code	Req. or Limit
92938	IC
92944	IC
92992	IC
92993	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
95941	IC
95943	IC
95999	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.
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
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
97127	PA for PT >20
97139	PA for PT >20; IC
97161	PA for PT >20
97162	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
97533	PA for OT >20
97530	PA for OT >20
97535	PA for OT >20
97542	PA for OT >20
97602	IC
97607	IC
97608	IC
97760	PA for OT >20
97761	PA for OT >20
97763	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

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

Service Code	Req. or Limit	Code	Req. or Limit
			specimens
98929	PA for OMT >20	99188	Once per three-month period
99050	Urgent care only	99195	For hematologic disorders only
99051	Urgent care only		
99070	IC; excluding family planning supplies, such as trays used in used in the collection of	99199	IC
		99499	IC
		99600	IC

604 Payable HCPCS Level II Service Codes

This section lists Level II HCPCS codes that are payable under MassHealth. For more detailed descriptions when billing for these 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	Req. or Limit	Service Code	Req. or Limit	Service Code	Req. or Limit
A4261	IC	G0270		J0364	IC
A4266		G0271		J0400	IC
A4267		G0279		J0401	
A4268		G0297		J0456	
A4269		G0455	IC	J0461	
A4641	IC	G0480		J0470	
A4648	IC	G0481		J0475	
A9500	IC	G0482		J0476	
A9502	IC	G0483		J0485	PA
A9503	IC	J0129	PA	J0490	PA
A9505	IC	J0131	IC	J0558	
A9512	IC	J0135	PA; IC	J0561	
A9537	IC	J0153		J0565	PA; IC
A9575		J0171		J0570	PA
A9576		J0178		J0571	PA; IC
A9577		J0202	PA	J0572	IC
A9578		J0215	PA; IC	J0573	IC
A9579		J0221	PA	J0574	IC
A9581		J0256		J0575	IC
A9585		J0257		J0585	PA
A9606	PA	J0285		J0586	PA
G0027		J0287		J0587	PA
G0105		J0289		J0588	PA
G0108		J0290		J0592	
G0109		J0295		J0594	
G0121		J0348		J0596	PA

604 Payable HCPCS Level II Service Codes

Service Code	Req. or Limit
J0598	PA
J0604	IC
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	
J0875	PA
J0878	
J0881	PA
J0882	PA
J0883	IC
J0884	IC
J0885	PA
J0887	PA
J0888	PA
J0890	PA; IC
J0894	
J0895	
J0897	PA

Service Code	Req. or Limit
J1000	
J1020	
J1030	
J1040	
J1050	
J1071	PA
J1094	IC
J1100	
J1130	PA; IC
J1160	
J1170	
J1190	
J1200	
J1212	
J1240	
J1260	IC
J1290	
J1300	PA
J1320	IC
J1322	PA; IC
J1428	PA: IC
J1438	PA; IC
J1439	PA
J1442	PA
J1447	
J1453	
J1455	IC
J1458	
J1459	
J1460	
J1555	PA
J1556	
J1557	PA
J1559	PA
J1561	PA
J1562	PA; IC
J1566	PA
J1568	PA
J1569	PA
J1571	
J1572	
J1573	IC

Service Code	Req. or Limit
J1575	
J1580	
J1599	PA; IC
J1602	PA
J1626	
J1627	PA; IC (PA=>2 units/28 days)
J1630	
J1642	
J1644	
J1645	
J1650	
J1652	
J1655	IC
J1670	
J1700	IC
J1710	IC
J1720	
J1726	PA; IC
J1729	PA; IC
J1740	PA
J1743	
J1744	PA; IC
J1745	PA
J1750	
J1756	PA
J1786	PA
J1790	IC
J1800	
J1815	
J1826	IC
J1830	IC
J1840	IC
J1850	IC
J1885	
J1890	IC
J1930	
J1931	
J1942	PA
J1950	PA
J1956	
J1990	IC

604 Payable HCPCS Level II Service Codes

Service Code	Req. or Limit	Service Code	Req. or Limit	Service Code	Req. or Limit
J2060		J2560		J3300	
J2150		J2562		J3301	
J2170	IC	J2675		J3302	IC
J2175		J2680		J3303	
J2182	PA; IC	J2700		J3315	
J2212	IC; PA	J2704		J3357	PA
J2248		J2760	IC	J3360	
J2250		J2778		J3370	
J2265	IC	J2785		J3380	PA
J2270		J2786	PA; IC	J3385	PA
J2274		J2788		J3396	
J2278		J2790		J3410	
J2300		J2791		J3411	
J2310		J2792		J3430	
J2315		J2793	PA; IC	J3465	
J2323		J2794		J3471	
J2326	PA; IC	J2795		J3472	IC
J2350	PA; IC	J2796	PA	J3473	
J2353		J2820		J3475	
J2354		J2840	PA; IC	J3486	
J2355	PA	J2910	IC	J3489	PA
J2357	PA	J2916		J3490	IC
J2358	PA	J2920		J3490-FP	IC
J2400		J2930		J3590	IC
J2405		J2940	PA; IC	J7030	
J2407	PA	J2941	PA; IC	J7040	
J2426	PA	J2997		J7050	
J2430		J3000		J7060	
J2440	IC	J3010		J7070	
J2460	IC	J3030	IC	J7120	
J2469		J3060	PA	J7131	IC
J2502	PA; IC	J3090	PA	J7205	
J2503		J3095	PA	J7296	IC
J2504		J3110	PA; IC	J7297	IC
J2505		J3121	PA	J7298	IC
J2507	PA	J3145	PA; IC	J7301	IC
J2510		J3230		J7303	IC
J2515		J3240		J7304	IC
J2540		J3243		J7307	IC
J2543		J3250		J7309	IC
J2545		J3262	PA	J7310	IC
J2550		J3285		J7311	IC

604 Payable HCPCS Level II Service Codes

Service Code	Req. or Limit	Service Code	Req. or Limit	Service Code	Req. or Limit
J7312		J7676	IC	J9176	PA
J7313		J7682		J9178	
J7315	IC	J7686	PA	J9179	PA
J7316		J7699	IC	J9181	
J7320	PA	J7799	IC	J9185	
J7321	PA	J7999	IC	J9190	
J7322	PA; IC	J8562	IC	J9200	
J7323	PA	J8655		J9201	
J7324	PA	J8670	PA; IC	J9202	PA
J7325	PA	J9000		J9205	PA
J7326	PA	J9015	IC	J9206	
J7327	PA	J9017		J9207	
J7328	PA; IC	J9019	PA	J9208	
J7336	PA	J9020	IC	J9209	
J7340	IC	J9022	PA; IC	J9211	
J7342	IC	J9023	PA; IC	J9212	IC
J7345	IC	J9025		J9213	IC
J7500		J9031		J9214	
J7502		J9032		J9215	IC
J7503		J9033		J9216	IC
J7504		J9034		J9217	PA
J7507		J9035		J9218	PA
J7508		J9039	PA	J9219	PA; IC
J7509		J9040		J9225	
J7510		J9041		J9226	
J7511		J9042	PA	J9228	
J7512		J9043	PA	J9230	
J7515		J9045		J9250	
J7517		J9047	PA	J9260	
J7518		J9050		J9261	PA
J7520		J9055		J9262	PA; IC
J7527		J9060		J9263	
J7599	IC	J9065		J9264	
J7608		J9070		J9266	
J7614	PA	J9098		J9267	
J7620		J9100		J9268	
J7626		J9120		J9271	PA
J7633	IC	J9130		J9280	
J7639		J9145	PA	J9293	
J7644		J9155	PA	J9295	PA
J7665	IC	J9160	IC	J9299	PA
J7669	IC	J9171		J9301	PA

604 Payable HCPCS Level II Service Codes

Service Code	Req. or Limit	Service Code	Req. or Limit	Service Code	Req. or Limit
J9302	PA	Q2009	IC	Q4133	
J9303		Q2017	IC	Q4161	IC
J9305		Q2028	IC; CD (covered	Q4162	IC
J9306	PA		with diagnosis of	Q4163	IC
J9307			lipodystrophy	Q4164	IC
J9308	PA		associated with	Q4165	IC
J9310	PA		or secondary to	Q5101	
J9315	PA		HIV only)	Q9950	
J9320		Q2035		Q9980	PA; IC
J9325	PA	Q2036	IC	S0020	IC
J9328		Q2037		S0021	IC
J9330		Q2038	IC	S0023	IC
J9340	IC	Q2043	PA	S0077	IC
J9351		Q2049	IC	S0190	IC
J9352		Q2050		S0191	IC
J9354	PA	Q4074		S0199	
J9355		Q4081		S0302	
J9357		Q4101		S2260 (CPA-2); IC	
J9360		Q4102		S3005	
J9370		Q4103	IC	S4989	IC
J9371	PA	Q4104	IC	S4993	
J9390		Q4106		T1023	
J9395	PA	Q4107		V2600	PA; IC
J9400	PA	Q4108	IC	V2610	PA; IC
J9999	IC	Q4110	IC	V2615	PA; IC
Q0138		Q4121		V2799	PA; IC
Q0139		Q4131			
Q0162		Q4132			

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.)
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.
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

605 Modifiers (cont.)

Modifier	Modifier Description
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FA	Left hand, thumb
FP	Service provided as part of family planning program
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

605 Modifiers (cont.)

Modifier	Modifier Description
	Program (VFC).)
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe
TC	Technical component. 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.

605 Modifiers (cont.)

Modifier	Modifier Description
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
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.

Modifier	Modifier Description
U1	Completed behavioral health screening using a standardized behavioral health-screening tool selected from the approved menu of tools found in Appendix W of your provider manual with "no behavioral health need identified" when administered by a physician, 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.

605 Modifiers (cont.)

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.