Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid

www.mass.gov/masshealth

MassHealth
Transmittal Letter UCC-1
January 2022

TO: Urgent Care Clinics Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth

RE: *Urgent Care Clinic Manual* (New Provider Manual)

Effective January 21, 2022, MassHealth will cover acupuncture services under MassHealth Standard, MassHealth CarePlus, and MassHealth CommonHealth, as well as for certain MassHealth Family Assistance members. This letter transmits a new provider Urgent Care Clinic provider manual.

New Provider Manual: Urgent Care Clinic Services

The *Urgent Care Clinic Manual* includes administrative and billing regulations for all providers as Subchapters 1-3. Instructions and other information relevant to all providers are reproduced in Subchapter 5 and all-provider appendices.

Provider-specific information about urgent care clinic services and codes are listed in Subchapter 4 and Subchapter 6.

New Regulation: 130 CMR 455.000 (Subchapter 4 of the Urgent Care Clinic Manual)

130 CMR 455.000: *Urgent Care Clinic Services* establishes a new provider type and standalone provider regulation for urgent care clinic services. The new regulation sets forth the requirements for an entity's enrollment as a MassHealth provider of urgent care clinic services, the requirements for the delivery of urgent care clinic services, and the member eligibility requirements for the receipt of these services.

New Subchapter 6: Urgent Care Clinic Services

Subchapter 6 of the *Urgent Care Clinic Manual* establishes the covered codes for urgent care clinic services.

MassHealth Website

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

Sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (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.)

Urgent Care Clinic Manual

Pages iv, 4-1 through 4-8, vi, 6-1 through 6-10

4. Program Regulations:

130 CMR 455.000: *Urgent Care Clinic Services*

455.401: Introduction 4-1
455.402: Definitions 4-1
455.403: Eligible Members 4-2
455.404: Provider Eligibility 4-2
455.405: Maximum Allowable Fees 4-3
455.406: Individual Consideration 4-3
455.407: Report Requirements 4-3
(130 CMR 455.408 through 455.412 Reserved)
455.413: Covered Services 4-4
455.414: Noncovered Services 4-4
455.415: Urgent Care Visits: Service Limitations 4-4
455.416: Laboratory Services: Introduction 4-4
455.417: Laboratory Services: Eligibility to Provide Services 4-4
455.418: Laboratory Services: Service Limitations 4-5
455.419: Laboratory Services: Services Performed by Outside Laboratories 4-6
455.420: Radiology Services: Introduction 4-6
455.421: Radiology Services: Service Limitations 4-6
455.422: Recordkeeping Requirements 4-7

455.401: Introduction

All urgent care clinics participating in MassHealth must comply with all MassHealth regulations including, but not limited to, 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

455.402: Definitions

The following terms used in 130 CMR 455.000 have the meanings given in 130 CMR 455.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 455.000 is not determined by these definitions, but by application of 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Primary or Elective Care — medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. Primary or elective care includes, but is not limited to, physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention, and referral when necessary.

Urgent Care – a term defined in 105 CMR 140.000: *Licensure of Clinics*.

Urgent Care Clinic (UCC) – an entity licensed as a clinic by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111, § 51 and 105 CMR 140.000: *Licensure of Clinics*, if in state, or by the licensing authority of its own state, if out of state, that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, administers its own budget and personnel, and is organized primarily for the purpose of rendering urgent care.

Urgent Care Visit – an in-person encounter between an eligible member and a licensed practitioner (such as a physician or nurse practitioner) or other medical professional under the direction of a licensed practitioner for the provision of urgent care as defined in 130 CMR 455.402.

455.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency covers UCC services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in 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) For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

455.404: Provider Eligibility

Payment for the services described in 130 CMR 455.000 will be made only to providers of UCC services who are participating in MassHealth on the date of service.

(A) In State. To participate in MassHealth, a UCC located in Massachusetts must

(1) operate under a clinic license issued by the Massachusetts Department of Public Health pursuant to 105 CMR 140.100 *et seq*.; and

(2) have a signed provider contract with the MassHealth agency.

(B) Out of State. To participate in MassHealth, an out-of-state UCC must obtain a MassHealth provider number and meet the following criteria:

(1) if the clinic is required by its own state's law to be licensed, the clinic must be licensed by the appropriate state agency under whose jurisdiction it operates;

(2) the clinic must participate in its state's Medicaid program (or the equivalent); and

(3) meet the conditions set forth in 130 CMR 450.109: *Out-of-state Services*.

455.405: Maximum Allowable Fees

(A) The Executive Office of Health and Human Services (EOHHS) determines the payment rate for UCC services in accordance with 101 CMR 317.00: *Rates for Medicine Services*, 101 CMR 318.00: *Rates for Radiology Services,* and 101 CMR 320.00: *Clinical Laboratory Services*.

(B) Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations.*

455.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Urgent Care Clinic 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 455.406(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 or pathology report. 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 455.407 for report requirements.

(B) The MassHealth agency considers the following factors when determining the appropriate payment for an individual consideration service:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the policies, procedures, and practices of other third-party insurers, both governmental and private;
(4) other standards and criteria as may be adopted by EOHHS or the MassHealth agency.

455.407: Report Requirements

A general written report or a discharge summary must accompany the claim for payment for any service that is listed in Subchapter 6 of the *Urgent Care Clinic 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.

Each urgent care clinic must provide a copy of the medical record of each urgent care visit to the MassHealth member at the end of the urgent care visit or as soon as available and, with the member's consent, provide a facsimile or electronically transmitted copy of the medical record of the urgent care visit to the member's primary care provider, if any. Such copies or transmission must be provided at no charge to the member. In the event that the member has a primary care provider, the urgent care clinic shall provide the member with the name and contact information of such primary care provider, in a manner to be prescribed by the MassHealth agency. In the event that the member does not have a primary care provider, the urgent care clinic shall

(1) notify the MassHealth agency that the member does not have a primary care provider, using a form that will be prescribed by the MassHealth agency; and

(2) provide the member with the names of primary care providers who participate in MassHealth and practice in the member's municipality of residence or an adjacent municipality, in a manner to be prescribed by the MassHealth agency.

(455.408 through 455.412 Reserved)

455.413: Covered Services

The MassHealth agency pays for medically necessary urgent care identified in Subchapter 6 of the *Urgent Care Clinic Manual*.

455.414: Noncovered Services

The MassHealth agency does not pay for the following services:

(A) services performed for experimental, unproven, cosmetic or otherwise medically unnecessary procedure or treatment;

(B) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment);

(C) services otherwise identified in the MassHealth regulations at 130 CMR 455.000 or 130 CMR 450.000: *Administrative and Billing Regulations* as not payable; or

(D) otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 455.414.

455.415: Urgent Care Visits: Service Limitations

The following restrictions and limitations apply to urgent care visits as defined in 130 CMR 455.402.

Treatments or Procedures. The UCC may bill for an urgent care visit, a treatment, or a procedure, but may not bill for more than one of these services provided to the same member on the same date when the services are performed in the same location. X-rays, laboratory tests, and certain diagnostic tests identified in Subchapter 6 of the *Urgent Care Clinic Manual* may be billed in addition to an urgent care visit.

455.416: Laboratory Services: Introduction

The MassHealth agency only pays UCCs for those laboratory services listed in Subchapter 6 of the *Urgent Care Clinic Manual*. The MassHealth agency pays a UCC for laboratory services that are medically necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of MassHealth members, subject to all the restrictions and limitations described in 130 CMR 455.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. In order for a UCC to be paid for any laboratory service, a written request for that service from an authorized prescriber must be present in the member's medical record.

455.417: Laboratory Services: Eligibility to Provide Services

A UCC may claim payment for the laboratory services listed in Subchapter 6 of the *Urgent Care Clinic Manual* only when all of the following conditions are met.

(A) The laboratory services are performed in the UCC.

(B) The laboratory tests are performed on properly and regularly calibrated equipment, and daily controls are carried out.

(C) The UCC has been certified by the Centers for Medicare & Medicaid Services (CMS) for performing in-house clinical laboratory services, based on the criteria set forth in the Clinical Laboratory Improvement Amendments (CLIA) of 1988, as it may be amended. In addition, the UCC's laboratory must maintain its own quality-control program and successfully participate in one or more proficiency testing programs that cover all Medicare-certified specialties and subspecialties of the laboratory. The UCC must make the results of the proficiency testing programs available to the MassHealth agency and the Attorney General's Medicaid Fraud Division upon request or during an on-site visit.

(D) If the UCC is located in-state, the UCC has been approved by the Massachusetts Department of Public Health to perform in-house clinical laboratory services. If the UCC is located out-of-state, in addition to meeting the requirements of 130 CMR 455.404(B), 455.417(A) through (C), and 130 CMR 450.109: *Out-of-state Services*, the UCC must also meet its own state's requirements for performing in-house clinical laboratory services.

455.418: Laboratory Services: Service Limitations

(A) The MassHealth agency does not pay a UCC for services listed as non-covered services or for which payment limits apply in accordance with the MassHealth *Independent Clinical Laboratory Manual* at 130 CMR 401.000: *Independent Clinical Laboratory*.

(B) The MassHealth agency does not pay a UCC 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).

(C) The MassHealth agency does not pay a UCC for the professional component of a clinical laboratory service. The MassHealth agency will pay a UCC for the professional component of an anatomical service, as provided in Subchapter 6 of the *Urgent Care Clinic Manual* (for example, bone marrow analysis or analysis of a surgical specimen).

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

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

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

(E) The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438: *Clinical Laboratory Services: Introduction*, 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.

(F) Some services listed in Subchapter 6 of the *Urgent Care Clinic Manual* are designated “I.C.,” an abbreviation for individual consideration. This means that a specific fee could not be established. The payment for an I.C. service will be determined by the MassHealth agency based on the designation of the test as entered on the claim form.

(G) A UCC may not bill for a visit when a member is being seen for laboratory services only.

455.419: Laboratory Services: Services Performed by Outside Laboratories

(A) A UCC may not bill the MassHealth agency for laboratory services provided outside the UCC. In this case, the testing laboratory should bill the MassHealth agency directly for those services.

(B) When sending a specimen to an outside laboratory, the UCC must include the member's MassHealth identification number and the UCC's MassHealth provider number.

455.420: Radiology Services: Introduction

The MassHealth agency will pay for the radiology services in Subchapter 6 of the *Urgent Care Clinic Manual* only when the services are provided at the written request of a licensed physician or dentist. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

455.421: Radiology Services: Service Limitations

(A) Definitions.

Global Fee – the rate of payment for the two components of a radiology service: the professional component and the technical component.

Professional Component – the component of a radiology service for interpreting a diagnostic test or image.

Technical Component – the component of a radiology service for the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses.

(B) Payment of the Global Fee. The MassHealth agency will pay a UCC the global fee for performing a radiology service at the UCC when one of the following conditions is met.

(1) The UCC owns or leases the equipment for providing the technical component of the service, employs a technician to provide the technical component of the service, and employs a board-certified or board-eligible radiologist to provide the professional component of the service.

(2) The UCC employs a board-certified or board-eligible radiologist to provide the professional component of the service and the UCC subcontracts with a licensed Medicare-certified entity to provide the technical component of the service.

(3) The UCC subcontracts with a licensed Medicare-certified entity to provide the professional and technical component of the service.

(C) Subcontracting for Radiology Services.

(1) All subcontracts between the UCC and the licensed Medicare-certified entity must be in writing, ensure continuity of care, and be consistent with all applicable provisions of 130 CMR 455.000.

(2) The UCC is legally responsible to the MassHealth agency for the performance of any subcontractor. The UCC must ensure that every subcontractor is licensed and Medicare certified, and that services are furnished in accordance with the MassHealth agency's regulations, including, but not limited to, those set forth in 130 CMR 450.000: *Administrative and Billing Regulations*. The UCC must submit claims for payment for radiology services provided hereunder in accordance with the MassHealth agency's regulations and applicable fee schedules.

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (*see* 130 CMR 455.422), the UCC must keep records of radiology services performed. All X-rays must be labeled 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.

455.422: Recordkeeping Requirements

(A) The urgent care clinic is responsible for ensuring the medical necessity of the services and maintaining test results in the member's health record. Payment for any service listed in 130 CMR 455.000 is conditioned upon its full and complete documentation in the member's medical record and must be maintained for at least six years. 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 UCC 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 UCC to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 455.422(C) would otherwise result in removal of medical records from the UCC's office.

(D) The medical record must include, but is not limited to
- (1) the date of each service;
- (2) the member's name, address, telephone number, date of birth, and MassHealth identification number;
- (3) the name, title, and signature of the person performing the service;
- (4) the member's medical history;
- (5) the diagnosis or chief complaint;
- (6) a written order for the tests or treatment to be performed and the respective results;
- (7) the name of the supervising physician;
- (8) clear indication of all findings, whether positive or negative, on examination;
- (9) any medications administered or prescribed, including strength, dosage, and regimen;
- (10) a description of any treatment given;
- (11) recommendations for additional treatments or consultations, when applicable;
- (12) pertinent findings on examination; and
- (13) any medical goods or supplies dispensed or prescribed.

REGULATORY AUTHORITY

130 CMR 455.000: M.G.L. c. 118E, §§ 7 and 12.

6. Service Codes and Descriptions

Introduction and Explanation of Abbreviations 6-1
Payable Radiology Service Codes 6-2
Payable Laboratory Service Codes 6-2
Payable Vaccine, Visit, and Surgery Service Codes 6-3
Modifiers 6-5

Appendix A. Directory A-1

Appendix C. Third-Party-Liability Codes C-1

Appendix D. Supplemental Instructions for TPL Exceptions D-1

Appendix E. Utilization Management Program E-1

Appendix F. Admission Guidelines F-1

Appendix T. CMSP Covered Codes T-1

Appendix U. DPH-Designated Serious Reportable Events That Are Not Provider Preventable Conditions U-1

Appendix V. MassHealth Billing Instructions for Provider Preventable Conditions V-1

Appendix W. EPSDT Services Medical and Dental Protocols and Periodicity Schedules W-1

Appendix X. Family Assistance Copayments and Deductibles X-1

Appendix Y. EVS Codes/Messages Y-1

Appendix Z. EPSDT/PPHSD Screening Services Codes Z-1

601 Introduction and Explanation of Abbreviations

MassHealth pays for the services represented by the codes listed in Subchapter 6 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 455.000: *Urgent Care Clinic Services* and 450.000: *Administrative and Billing Regulations*. An urgent care clinic may request prior authorization (PA) for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Urgent Care Clinic Manual*.

For complete descriptions of the service codes listed in Subchapter 6, MassHealth providers must refer to the American Medical Association's latest *Current Procedural Terminology* (CPT) codebook and to the HCPCS Level II codebook (or the Centers for Medicare & Medicaid Services website at www.cms.gov).

The following abbreviation is used in Subchapter 6.

IC indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim. See 130 CMR 450.271.

Note: Rates paid by MassHealth for covered codes under this Subchapter 6 for drugs, vaccines, and immune globulins administered in a provider's office are as specified in 101 CMR 317.00: *Rates for Medicine Services*. 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 provider'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 provider's office that are listed in 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 <u>Payable Radiology Service Codes</u>

This section lists radiology service codes that are payable under MassHealth.

70030	71101	72190	73501
70100	71110	72200	73502
70140	71111	72220	73503
70150	71120	73000	73521
70160	71130	73010	73522
70200	72020	73020	73523
70210	72040	73030	73551
70220	72050	73040	73552
70250	72052	73050	73560
70260	72070	73060	73562
70328	72072	73070	73564
70330	72074	73080	73565
70360	72080	73090	73590
71045	72082	73100	73592
71046	72083	73110	73600
71047	72100	73120	73610
71048	72110	73130	73620
71100	72170	73140	
73630	74018	74022	
73650	74019	76010	
73660	74021		

603 <u>Payable Laboratory Service Codes</u>

This section lists CPT codes and HCPCS Level II codes that are payable under MassHealth.

80047	82010	86309	86706	87102
80048	82150	86328 IC	86707	87106
80053	82248	86580	86709	87110
80074	82270	86588	86757	87168
80076	82272	86592	86780	87172
80176	82310	86593	86803	87177
80178	82550	86618	86850	87181
80305	82947	86631	86901	87184
80307	82948	86632	87045	87186
81000	83036	86694	87046	87205
81001	85004	86696	87070	87209
81002	85014	86701	87077	87210
81003	85018	86702	87081	87220
81005	85025	86703	87086	87252
81015	85027	86704	87088	87270
81025	86308	86705	87101	87280

603 Payable Laboratory Service Codes (cont.)

87320	87420	87522	87637	87810
87324	87425	87529	87650	87850
87328	87426	87535	87651	87880
87329	87449	87590	87660	87899
87338	87490	87591	87661	87905
87340	87491	87634	87804	
87341	87502	87635	87807	
87390	87521	87636	87808	

604 Payable Vaccine, Visit, and Surgery Service Codes

(A) The following vaccine service codes have special requirements or limitations.

Service Code	Special Requirement or Limitation
U0002	Any technique, multiple types or subtypes (including all targets)
U0003	Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19])
U0004	2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19)
0001A	Immunization administration for Vaccines/Toxoids
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine.
0003A	Immunization administration for third dose of Pfizer-BioNTech vaccine
0004A	Immunization administration for the booster dose of the Pfizer and Moderna vaccine products
0011A	Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0034A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine

604 Payable Vaccine, Visit, and Surgery Service Codes (cont.)

(B) The following visit service codes have special requirements or limitations.

Service Code	Special Requirement or Limitation
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine
93000	EKG tracing with interpretation & report documented on same day as the EKG was taken
93005	EKG tracing only / no interpretation
93010	EKG tracing with interpretation & report documented on a different day as the EKG was taken
93040	Rhythm ECG One to three leads; with interpretation and report
94640	Treatment of acute airway obstruction
96360	Intravenous (IV) infusions for hydration purposes for first 31 minutes to an hour
96361	Intravenous infusion, hydration
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis
96372	Therapeutic, prophylactic, or diagnostic injection
99202	Office or other outpatient visit for the evaluation and management of a new patient
99203	Office or other outpatient visit for the evaluation and management of a new patient
99204	Office or other outpatient visit for the evaluation and management of a new patient
99205	Office or other outpatient visit for the evaluation and management of a new patient
99211	Office or outpatient visit with an established patient in an office or outpatient setting
99212	Office or outpatient visit with an established patient in an office or outpatient setting
99213	Office or outpatient visit with an established patient in an office or outpatient setting
99214	Office or outpatient visit with an established patient in an office or outpatient setting
99215	Office or outpatient visit with an established patient in an office or outpatient setting
90632	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90636	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90656	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age
90658	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90686	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90688	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90715	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)
90756	Covered for members >19; available free of charge through the Massachusetts Immunization Program for children younger than 19 years of age (IC)

604 Payable Vaccine, Visit, and Surgery Service Codes (cont.)

(C) The following surgical service codes have special requirements or limitations.

Service Code	Special Requirement or Limitation
10060	Incision and Drainage Procedures on the Skin, Subcutaneous and Accessory Structures for a single cyst
10061	Incision and Drainage Procedures on the Skin, Subcutaneous and Accessory Structures for complex or multiple cysts
10080	Incision and drainage of a pilonidal cyst
10081	Incision and drainage for a “complicated” incision and drainage of a pilonidal cyst
10120	Simple Incision and Drainage Procedures on the Skin, Subcutaneous and Accessory Structures
10121	Complex Incision and Drainage Procedures on the Skin, Subcutaneous and Accessory Structures
10140	Incision and drainage of hematoma, seroma or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla or cyst
11042	Under Debridement Procedures on the Skin
11200	Removal of Benign and Malignant Skin Lesions
11730	Indicates partial or complete avulsion of the nail (double check the medicine/physician regs for accuracy then list them under the modifies section)
11740	Evacuation of a subungual hematoma
11750	Excision of the nail and the nail matrix
11760	Emergency nail bed repair
11765	Wedge excision of the nail fold hypertrophic granulation tissue with removal of the offending portion of the nail
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)
12005	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)
12006	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes
12013	Repair of wound (2.6 to 5.0 centimeters) of the face, ears, eyelids, nose, lips, and/or mucous membranes
12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm
12015	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm
12016	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm
12020	Treatment of superficial wound dehiscence; simple closure
12021	Treatment of superficial wound dehiscence; with packing

604 Payable Vaccine, Visit, and Surgery Service Codes (cont.)

12031	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less
12032	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm
12034	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm
12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
12051	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
16000	Initial treatment, first degree burn, when no more than local treatment is required
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)
16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)
16030	Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)
20551	Injection(s); single tendon origin/insertion
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia
24640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
26010	Drainage of finger abscess; simple
26011	Drainage of finger abscess; complicated (eg, felon)
26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation
27808	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); without manipulation
27816	Closed treatment of trimalleolar ankle fracture; without manipulation
28190	Removal of foreign body, foot; subcutaneous
28192	Removal of foreign body, foot; deep
28193	Removal of foreign body, foot; complicated
28400	Closed treatment of calcaneal fracture; without manipulation
28430	Closed treatment of talus fracture; without manipulation

604 Payable Vaccine, Visit, and Surgery Service Codes (cont.)

28450 Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
28510 Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each
28660 Closed treatment of interphalangeal joint dislocation; without anesthesia
29105 Application of Risser jacket, localizer, body; including head
29125 Application of short arm splint (forearm to hand); static
29126 Application of short arm splint (forearm to hand); dynamic
29130 Application of finger splint; static
29131 Application of finger splint; dynamic
29240 Strapping; shoulder (eg, Velpeau)
29260 Strapping; elbow or wrist
29280 Strapping; hand or finger
29505 Application of long leg splint (thigh to ankle or toes)
29515 Application of short leg splint (calf to foot)
29530 Strapping; knee
29540 Strapping; ankle and/or foot
29550 Strapping; toes
29580 Strapping; Unna boot
29705 Removal or bivalving; full arm or full leg cast
30300 Removal foreign body, intranasal; office type procedure
30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30905 Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
40830 Closure of laceration, vestibule of mouth; 2.5 cm or less
46083 Incision of thrombosed hemorrhoid, external
51701 Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)
51702 Insertion of temporary indwelling bladder catheter; simple (eg, Foley)
64450 Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
65205 Removal of foreign body, external eye; conjunctival superficial
69000 Drainage external ear, abscess or hematoma; simple
69200 Removal foreign body from external auditory canal; without general anesthesia
69209 Removal impacted cerumen using irrigation/lavage, unilateral
69210 Removal impacted cerumen requiring instrumentation, unilateral

(D) The following other codes have special requirements or limitations.

Service Code	Special Requirement or Limitation
A6448	Light compression bandage, elastic, knitted/woven
A6449	Light compression bandage, elastic, knitted/woven
E0100	Cane adjust/fixed used in durable medical equipment
E0105	Cane, quad or three prongs, used in Used durable medical equipment
E0110	Crutches, forearm, includes crutches used in used durable medical equipment
E0114	Crutches, forearm, includes crutches used in used durable medical equipment
E0117	Underarm spring assist crutch used in used durable medical equipment
J0171	Adrenalin epinephrine inject

604 Payable Vaccine, Visit, and Surgery Service Codes (cont.)

J0295 Injection, ampicillin sodium/sulbactam sodium
J0561 Injection, penicillin g benzathine
J0696 Injection, ceftriaxone sodium
J0780 Injection, prochlorperazine
J1030 Injection, methylprednisolone acetate
J1040 Injection, methylprednisolone acetate
J1100 Injection, dexamethasone sodium phosphate
J1200 Injection, diphenhydramine hcl
J1815 Insulin injection
J1885 Injection, ketorolac tromethamine
J2405 Injection, ondansetron hydrochloride
J2550 Injection, promethazine hcl
J2920 Methylprednisolone injection
J2930 Methylprednisolone injection
J3030 Injection, sumatriptan succinate, 6 mg
J3301 Injection, triamcinolone acetonide
J7030 Infusion, normal saline solution
J7040 Infusion, normal saline solution
J7510 Prednisolone oral per 5 mg
J7512 Prednisone, immediate release or delayed release
L0120 Cervical, flexible, non-adjustable, prefabricated, off-the-shelf
L1810 Knee orthosis, elastic with joints
L1812 Knee orthosis, elastic with joints, prefabricated
L1830 Knee orthosis, elastic with joints, prefabricated
L1832 Knee orthosis, immobilizer, canvas longitudinal, prefabricated
L1833 Knee orthosis, adjustable knee joints
L3260 Surgical boot/shoe
L3807 Wrist hand finger orthosis
L3809 Wrist hand finger orthosis, without joint(s)
L3908 Wrist hand orthosis, wrist extension control cock-up
L3925 Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip)
L3984 Upper extremity fracture orthosis, wrist
L4350 Ankle control orthosis, stirrup style, rigid, includes any type interface
L4360 Walking boot, pneumatic and/or vacuum, with or without joints
L4361 Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material
Q0162 Ondansetron 1 mg, oral, fda approved prescription anti-emetic

605 Modifiers

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

Modifier	Description
26	Professional component
TC	Technical component

This publication contains codes that are copyrighted by the American Medical Association. Certain terms used in the service descriptions for HCPCS codes are defined in the *Current Procedural Terminology (CPT) Professional* codebook.

This page is reserved