MassHealth
Diagnostic and Surgical Facility Bulletin 6
April 2001

TO: Diagnostic and Surgical Facilities Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: HCFA Common Procedure Coding System (HCPCS) Update

Introduction

The federal government has revised the HCFA Common Procedure Coding System (HCPCS) for MassHealth billing.

The purpose of this bulletin is to inform freestanding magnetic resonance imaging (MRI) centers that the Division will cover the service codes listed later in this bulletin for dates of service provided on or after May 1, 2001. Descriptions for these service codes must be obtained using the American Medical Association’s 2001 Current Procedural Terminology (CPT) manual.

Payment

These covered services are in addition to those listed in the Diagnostic and Surgical Facility Bulletin 5, issued in August 2000. In accordance with Division regulations, payments are subject to the terms and conditions of 130 CMR 433.000 and 450.000.

Payment Requirements

Payment for these new codes will be determined through individual consideration (I.C.) until the Division of Health Care Finance and Policy establishes specific rates and these rates are incorporated into the appropriate regulation. All claims using the service codes listed in this bulletin must be submitted on paper with a report. The Division will deny any claims submitted electronically.
Payment Requirements (cont.)

A radiology report with the radiologist interpretation must accompany the claim for procedures designated for individual consideration. The Division will determine the appropriate payment based on the documentation that is submitted to support the use of the service code. If the documentation is illegible or incomplete, or if no report is submitted, the Division will deny the claim with the applicable error code.

Questions

If you have any questions, please contact the MassHealth Provider Services Department at (617) 628-4141 or 1-800-325-5231.
2001 MassHealth Service Code Additions

The following service codes are covered under individual consideration until the Division of Health Care Finance and Policy establishes specific rates and these rates are incorporated into the appropriate regulation. Refer to the 2001 American Medical Association’s Current Procedural Terminology manual for service code descriptions.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>70542</td>
<td>70548</td>
<td>73222</td>
<td>74182</td>
</tr>
<tr>
<td>70543</td>
<td>70549</td>
<td>73223</td>
<td>74183</td>
</tr>
<tr>
<td>70544</td>
<td>72195</td>
<td>73718</td>
<td>76393</td>
</tr>
<tr>
<td>70545</td>
<td>72197</td>
<td>73719</td>
<td></td>
</tr>
<tr>
<td>70546</td>
<td>73218</td>
<td>73722</td>
<td></td>
</tr>
<tr>
<td>70547</td>
<td>73219</td>
<td>73723</td>
<td></td>
</tr>
</tbody>
</table>