**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](http://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.)*

1. The secondary diagnosis name(s) and ICD-CM code(s) pertinent to any comorbid conditions, if present;
2. A description of the specific arthroscopic/arthroplasty procedure and appropriate CPT code(s) for the procedure being requested;
3. 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;
4. 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;
5. A summary of the nonoperative, conservative treatment(s) that have been tried and have been unsuccessful in managing the patient’s condition;
6. Any risk factors and/or comorbid conditions; and
7. 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](http://www.mass.gov/masshealth-transmittal-letters).

To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

**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.

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21123

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22841

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55200

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58350

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58752

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59412

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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.

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)

Service

Code Req. or Limit

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

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 PA1

27446 PA1

27447 PA1

27486 PA1

27487 PA1

27488 PA1

27599 IC

27899 IC

28890 PA

Service

Code Req. or Limit

28899 IC

29799 IC

29800 PA

29804 PA

29870 PA1

29873 PA1

29874 PA1

29875 PA1

29876 PA1

29877 PA1

29879 PA1

29880 PA1

29881 PA1

29882 PA1

29883 PA1

29884 PA1

29885 PA1

29886 PA1

29887 PA1

29888 PA1

29889 PA1

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

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

Service

Code Req. or Limit

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)

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)

Service

Code Req. or Limit

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

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

Service

Code Req. or Limit

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

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

Service

Code Req. or Limit

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

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

Service

Code Req. or Limit

 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

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

Service

Code Req. or Limit

 years of age

90867 IC

90868 PA for >30 sessions per course treatment1*;* 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

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

Service

Code Req. or Limit

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

Service

Code Req. or Limit

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

Code Req. or Limit

 specimens

99188 Once per three-month period

99195 For hematologic disorders only

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](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html).

Service Req. or

Code Limit

A4261 IC

A4266

A4267

A4268

A4269

A4641 IC

A4648 IC

A9500 IC

A9502 IC

A9503 IC

A9505 IC

A9512 IC

A9537 IC

A9575

A9576

A9577

A9578

A9579

A9581

A9585

A9606 PA

G0027

G0105

G0108

G0109

G0121

Service Req. or

Code Limit

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

Service Req. or

Code Limit

J0364 IC

J0400 IC

J0401

J0456

J0461

J0470

J0475

J0476

J0485 PA

J0490 PA

J0558

J0561

J0565 PA; IC

J0570 PA

J0571 PA; IC

J0572 IC

J0573 IC

J0574 IC

J0575 IC

J0585 PA

J0586 PA

J0587 PA

J0588 PA

J0592

J0594

J0596 PA

Service Req. or

Code 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 Req. or

Code 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 Req. or

Code 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

Service Req. or

Code Limit

J2060

J2150

J2170 IC

J2175

J2182 PA; IC

J2212 IC; PA

J2248

J2250

J2265 IC

J2270

J2274

J2278

J2300

J2310

J2315

J2323

J2326 PA; IC

J2350 PA; IC

J2353

J2354

J2355 PA

J2357 PA

J2358 PA

J2400

J2405

J2407 PA

J2426 PA

J2430

J2440 IC

J2460 IC

J2469

J2502 PA; IC

J2503

J2504

J2505

J2507 PA

J2510

J2515

J2540

J2543

J2545

J2550

Service Req. or

Code Limit

J2560

J2562

J2675

J2680

J2700

J2704

J2760 IC

J2778

J2785

J2786 PA; IC

J2788

J2790

J2791

J2792

J2793 PA; IC

J2794

J2795

J2796 PA

J2820

J2840 PA; IC

J2910 IC

J2916

J2920

J2930

J2940 PA; IC

J2941 PA; IC

J2997

J3000

J3010

J3030 IC

J3060 PA

J3090 PA

J3095 PA

J3110 PA; IC

J3121 PA

J3145 PA; IC

J3230

J3240

J3243

J3250

J3262 PA

J3285

Service Req. or

Code Limit

J3300

J3301

J3302 IC

J3303

J3315

J3357 PA

J3360

J3370

J3380 PA

J3385 PA

J3396

J3410

J3411

J3430

J3465

J3471

J3472 IC

J3473

J3475

J3486

J3489 PA

J3490 IC

J3490-FP IC

J3590 IC

J7030

J7040

J7050

J7060

J7070

J7120

J7131 IC

J7205

J7296 IC

J7297 IC

J7298 IC

J7301 IC

J7303 IC

J7304 IC

J7307 IC

J7309 IC

J7310 IC

J7311 IC

Service Req. or

Code Limit

J7312

J7313

J7315 IC

J7316

J7320 PA

J7321 PA

J7322 PA; IC

J7323 PA

J7324 PA

J7325 PA

J7326 PA

J7327 PA

J7328 PA; IC

J7336 PA

J7340 IC

J7342 IC

J7345 IC

J7500

J7502

J7503

J7504

J7507

J7508

J7509

J7510

J7511

J7512

J7515

J7517

J7518

J7520

J7527

J7599 IC

J7608

J7614 PA

J7620

J7626

J7633 IC

J7639

J7644

J7665 IC

J7669 IC

Service Req. or

Code Limit

J7676 IC

J7682

J7686 PA

J7699 IC

J7799 IC

J7999 IC

J8562 IC

J8655

J8670 PA; IC

J9000

J9015 IC

J9017

J9019 PA

J9020 IC

J9022 PA; IC

J9023 PA; IC

J9025

J9031

J9032

J9033

J9034

J9035

J9039 PA

J9040

J9041

J9042 PA

J9043 PA

J9045

J9047 PA

J9050

J9055

J9060

J9065

J9070

J9098

J9100

J9120

J9130

J9145 PA

J9155 PA

J9160 IC

J9171

Service Req. or

Code Limit

J9176 PA

J9178

J9179 PA

J9181

J9185

J9190

J9200

J9201

J9202 PA

J9205 PA

J9206

J9207

J9208

J9209

J9211

J9212 IC

J9213 IC

J9214

J9215 IC

J9216 IC

J9217 PA

J9218 PA

J9219 PA; IC

J9225

J9226

J9228

J9230

J9250

J9260

J9261 PA

J9262 PA; IC

J9263

J9264

J9266

J9267

J9268

J9271 PA

J9280

J9293

J9295 PA

J9299 PA

J9301 PA

Service Req. or

Code Limit

J9302 PA

J9303

J9305

J9306 PA

J9307

J9308 PA

J9310 PA

J9315 PA

J9320

J9325 PA

J9328

J9330

J9340 IC

J9351

J9352

J9354 PA

J9355

J9357

J9360

J9370

J9371 PA

J9390

J9395 PA

J9400 PA

J9999 IC

Q0138

Q0139

Q0162

Service Req. or

Code Limit

Q2009 IC

Q2017 IC

Q2028 IC; CD (covered with diagnosis of lipodystrophy associated with or secondary to HIV only)

Q2035

Q2036 IC

Q2037

Q2038 IC

Q2043 PA

Q2049 IC

Q2050

Q4074

Q4081

Q4101

Q4102

Q4103 IC

Q4104 IC

Q4106

Q4107

Q4108 IC

Q4110 IC

Q4121

Q4131

Q4132

Q4107Service Req. or

Code Limit

Q4133

Q4161 IC

Q4162 IC

Q4163 IC

Q4164 IC

Q4165 IC

Q5101

Q9950

Q9980 PA; IC

S0020 IC

S0021 IC

S0023 IC

S0077 IC

S0190 IC

S0191 IC

S0199

S0302

S2260 (CPA-2); IC

S3005

S4989 IC

S4993

T1023

V2600 PA; IC

V2610 PA; IC

 V2615 PA; IC

V2799 PA; IC

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

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

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.

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 AppendixW

 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, usedfor 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](http://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.

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