Community Health Centers
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

This payment policy applies to Community Health Centers (CHCs) contracted with Fallon Health and reimbursed in accordance with MassHealth Community Health Center Manual Subchapter 4 (130 CMR 405.000: Community Health Center Services) and Subchapter 6. The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Behavioral Health services rendered at a CHC are managed by the Plan's contracted behavioral health vendor, Carelon.

CHCs must be licensed as a clinic by the Massachusetts Department of Public Health (105 CMR 140.000: Licensure of Clinics). For the purposes of 130 CMR 405.000, the term "licensee" means the entity named in the license issued by the Department of Public Health. A CHC can be comprised of multiple sites that are identified on the license as "satellites." Services provided at satellites are considered to be provided on site.

Payment for the services described in this payment policy will be made only to CHCs who also are participating in MassHealth on the date of service, as further described herein.

A Community Health Center (CHC) is defined in 105 CMR 140.1100 as a federally-qualified health center operating in conformance with federal rules for community health centers under 42 U.S.C. 254b and currently participating in the Massachusetts Medicaid program, or a community health center with an active provider agreement with MassHealth under 130 CMR 405.000: Community Health Center Services.

The CHC must be open for the delivery of medical services to the public on a regular schedule for a minimum of 20 hours per week. The schedule must be arranged to afford maximum access to members, such as by regularly scheduled evening or weekend clinic hours.

Except as specified in 130 CMR 405.407(A) and (B), a CHC must have at least one licensed physician on site during its hours of operation to treat medical problems outside the expertise of other health practitioners on the CHC's staff. This physician may leave the CHC for limited periods to visit CHC patients in their homes, in hospitals, or in nursing facilities; but he or she must be on call to the CHC during such periods.

A CHC must provide on site the medical services specified in 130 CMR 405.408. Services that must be provided by a CHC on site are the following: (A) audiology services; (B) chiropractor services; (C) dental services; (D) electrocardiogram (EKG) services; (E) laboratory services; (F) medical specialty services such as, but not limited to, cardiology and neurology; (G) mental health services, including psychological testing; (H) occupational therapy services; (I) pharmacy services; (J) physical therapy services; (K) podiatry services; (L) radiology services; (M) speech/language therapy services; and (N) vision care services.

It is not necessary that all of the services listed in 130 CMR 408.408 be available during all hours of the CHC's operation, but all must be available to members on a regularly scheduled basis with sufficient frequency to ensure access to care and continuity of care. If the CHC does not serve patients of a particular age group, upon the prior written approval of the MassHealth agency, the CHC will not be required to provide pediatric or obstetrical/gynecological services or both.

All of the services listed in 130 CMR 405.409 must be provided on site or, alternatively, through a referral network. All services provided on site must be furnished by practitioners qualified to provide the service that are employees or contractors of the CHC. A service furnished by a practitioner other than an employee or contractor of the CHC for which the practitioner, rather than the CHC, claims payment is not considered to be “on site,” even if the service is provided on CHC premises. With the exceptions of audiology, electrocardiogram, laboratory, and radiology services provided on site (for which such services must be furnished and payment claimed by the CHC in accordance with applicable provisions set forth in 130 CMR 405.000 and Subchapter 6 of the Community Health Center Manual), all services listed in 130 CMR 405.409 that are provided on site must be furnished, and associated payment claimed by the CHC, in compliance with the applicable MassHealth regulations and subchapter 6 for each such service.

All services listed in 130 CMR 405.409 that are provided by referral must be based on written agreements between the CHC and each referral provider to ensure continuity of care, exchange of relevant health information such as test results and records, and avoidance of service duplication. Each referral provider must be a participating provider in MassHealth, or enrolled as a Nonbilling Managed Care Entity (MCE) Network-only Provider. Payment for the services provided by the referral provider must be claimed by the referral provider in compliance with the applicable MassHealth regulations for such service.

.A CHC must provide either:
1) 24-hour-a-day on-site medical or emergency services or both; or
2) an after-hours telephone service, and have a written agreement with a provider of 24- hour-a-day medical or emergency service or both.

A tape-recorded telephone message instructing members to call an emergency backup provider or a hospital emergency room does not suffice as compliance with this requirement.

Definitions

Emergency medical condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of an Enrollee or another person or, in the case of a pregnant individual, the health of the individual or their unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant individual, as further defined in Section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Medically necessary or medical necessity – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Reimbursement

The Plan does not reimburse Current Dental Terminology (CDT) codes for MassHealth ACO members. All claims billed with CDT codes (including D9450) must be submitted to MassHealth.

Behavioral Health services rendered by CHCs are managed by the Plan's behavioral health vendor.

Claims for psychological and neuropsychological testing services (CPT 96130, 96132) must be submitted to the Plan's behavioral health vendor.

Nonreimbursable services
The Plan does not pay a CHC for performing, administering, or dispensing experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments.

The Plan does not pay a CHC for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, the Plan does pay a CHC for the diagnosis of male or female infertility.

MassHealth Managed Care Entity (MCE) Bulletin 84 Services
Effective for dates of service on or after January 1, 2022, Fallon Health and our contracted vendors will reimburse claims for the codes/services listed in MCE Bulletin 84 when rendered by in-network and out-of-network CHCs. Prior authorization is not required for the codes/services listed in MCE Bulletin 84 when rendered by in-network or out-of-network CHCs. Claims are subject to medical necessity review, pre-and post-payment claims edits, etc.

All-inclusive individual medical visit (T1015)
An individual medical visit is defined as a face-to-face meeting at the CHC between a member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse for purposes of examination, diagnosis, or treatment.

When claiming payment for visits or vaccines, a CHC must bill according to the service codes listed in Subchapter 6, Section 604. A visit during which a member sees more than one professional for the same medical problem or general purpose must be claimed as only one visit. See Visit Service Limiatations (130 CMR 405.421) below for additional requirements.

The cost of vaccine administration is included in the CHC visit rate and is not separately payable (Subchapter 6, Section 604 Payable Visit, Vaccine Service and Drug Codes).

The Plan will reimburse T1015 once per date of service per member.

Update to T1015 – TH modifier use
In accordance with MassHealth Managed Care Entity Bulletin 140 (November 2025), effective November 1, 2025, all individual medical visits billed by CHCs using CPT code T1015 for services performed by a certified nurse midwife or obstetrician gynecologist (physician MDs/DOs only) must be accompanied by the TH modifier. The TH modifier must be used for all such visits, regardless of whether the service performed was related to prenatal or postpartum care.

CPT Code	Modifier	Current Description (Until 10/31/2025)	New Description (Effective 11/1/2025)
T1015	TH	Use for a medical visit with a nurse midwife for a prenatal or postpartum service	Use for all individualmedical visits with a certified nurse midwife or obstetrician gynecologist

Administrative Bulletin 25-25: Effective November 1, 2025, EOHHS is updating the description for CHCs' use of T1015-TH in 101 CMR 304.00: Rates for Community Health Centers.

Visit service limitations (130 CMR 405.421)
The following restrictions and limitations apply to visits as defined in 130 CMR 405.402.

(A) Individual Medical Visit (T1015) – An individual medical visit, including family planning, may not be for an individual mental health service or for HIV pre- or post-test counseling visits.

(B) Individual Mental Health Visit (T1040) – An individual mental health visit conducted by a person other than a psychiatrist or an advanced practice registered nurse (APRN) with a

graduate degree and advanced training in psychiatric care (a psychiatric clinical nurse specialist or a psychiatric mental health nurse practitioner) is not reimbursable. Other mental health services provided by qualified clinicians and properly billed are reimbursable, but not as Individual Mental Health Visits.

(C) Group Clinic Visit (T1015 HQ) – All instructional group sessions for members must be carried out by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, or registered nurse. A group visit conducted by other kinds of professionals (for example, social workers, counselors, or nutritionists) is not reimbursable as a group clinic visit. These limitations do not apply to group clinic visits for tobacco cessation.

(D) HIV Pre- and Post-test Counseling Visits (99402) – The CHC may be reimbursed for a maximum of two HIV pre-test counseling and two HIV post-test counseling visits per member per test. A maximum of four pre-test counseling visits and four post-test counseling visits per calendar year per member are reimbursable.

(E) Home Visit – A home visit must be used to deliver episodic care in the member's home when a health practitioner has determined that it is not advisable for the member to visit the CHC. The medical record must document the reasons for a home visit. A house-bound member with chronic medical and nursing care needs must be referred to a Medicare-certified home health agency.

(F) Treatments or Procedures – The CHC may bill for a 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. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit. Examples of treatments or procedures are a vasectomy, colposcopy, or an amniocentesis. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit.

(G) Immunization or Injection – (1) The CHC may bill for either an office visit or vaccine administration, but may not bill for both an office visit and vaccine administration for the same member on the same date when the office visit and the vaccine administration are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the vaccine was administered. (2) The Plan pays for the cost of the injectable material unless the Massachusetts Department of Public Health distributes the injectable material free of charge.

(H) Urgent Care – The Plan pays an enhanced fee for urgent care when such care is provided at the CHC Monday through Friday from 5:00 P.M. to 6:59 A.M., and from Saturday at 7:00 A.M. through Monday at 6:59 A.M.

Vaccine and vaccine administration services provided by CHCs
CHCs provide essential services to MassHealth members, including vaccine and vaccine administration services. CHCs may bill the appropriate vaccine and vaccine administration codes, as described in the MassHealth Community Health Center Provider Manual, however, in the event that such services are provided as part of an individual medical visit, as defined in 130 CMR 405.402, CHCs may bill the Plan for the individual medical visit or the vaccine administration, but cannot bill for both services provided in the same visit. (*Source: MassHealth Community Health Center Bulletin 109 May 2021*).

Vaccine administration is separately payable with an EPSDT visit.

Subchapter 6, Section 604(B) lists the evaluation and management codes that are payable under MassHealth. Subchapter 6, Section 604(C) lists the vaccine administration service codes are payable in addition to the evaluation and management visit service codes in this Section 604(B), provided that the vaccine administration is a medically necessary, separately identifiable service. Under these circumstances, the CHC may append modifier 25 to the evaluation and management visit service code.

The CHC is responsible for ensuring that the services provided are billed appropriately and according to MassHealth regulations, including but not limited to 130 CMR 405.000: Community Health Center Services and 130 CMR 450.000: Administrative and Billing Regulations. CHCs that bill for an individual medical visit for visits in which vaccine administration services are provided must ensure that the visit amounts to an individual medical visit as defined under 130 CMR 405.402: Definitions. For example, a visit involving a meeting between a member and a physician, nurse practitioner, physician assistant or registered nurse at the CHC and including COVID-19 vaccine education/counseling, administration of the vaccine, and monitoring for adverse reactions to the vaccine in a single visit may be billed as an individual medical visit using code T1015 (*Source: MassHealth Community Health Center Bulletin 109 May 2021*).

All children < 19 years of age enrolled in MassHealth are eligible for vaccines at no cost through the Federal Vaccines for Children Program. The Massachusetts (MA) Department of Public Health (DPH) Vaccine Program distributes federal and state-suppled vaccines for all children in Massachusetts. For a list of vaccines and the age groups for whom state-supplied vaccine is available for, see https://www.mass.gov/info-details/vaccine-availability-and-ordering#childhood-vaccine-availability.

The Plan does not reimburse vaccines available at no cost through the MA DPH Vaccine Program.

Payable vaccine service codes are listed in the Community Health Center Manual, Subchapter 6, Subsection 604(D). Many vaccine service codes have special requirements or limitations.

Effective January 3, 2023, CHCs must bill vaccines received at no cost from the MA DPH Vaccine Program with the SL modifier. The Plan will pay $0 for state-supplied vaccines, including vaccines billed with the SL modifier (*Source: MassHealth All Provider Bulletin 359 January 2023*).

Vaccine counseling services
In accordance with MassHealth All Provider Bulletin 362, effective for dates of service on or after February 1, 2023, CHCs may bill and receive payment for providing clinically appropriate, medically necessary stand-alone vaccine counseling services using HCPCS codes G0310-G0315.

CHCs rendering vaccine counseling services must do so in accordance with all applicable laws and regulations, including 130 CMR 405.000: Community Health Center Services.

CHCs may bill for either an individual medical visit or vaccine counseling services, but may not bill for both in a single visit (*MassHealth All Provider Bulletin 362 March 2023*).

Urgent care
Urgent care is defined as medical services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care does not include elective or primary care (130 CMR 405.402).

CHCs may bill and receive payment for urgent care when such care is provided at the CHC Monday through Friday from 5:00 P.M. to 6:59 a.m., and from Saturday at 7:00 a.m. through Monday at 6:59 a.m. CHCs must use CPT 99050 to report urgent care provided Monday through Friday from 5:00 p.m. to 6:59 a.m., and Saturday 7:00 a.m. to Monday 6:59 a.m (CMR 405.421(H)). CPT code 99050 may be billed in addition to the individual medical visit (T1015).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
The Plan pays for all medically necessary community health care for EPSDT-eligible members in accordance with 130 CMR 450.140: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction, without regard to service limitations described in 130 CMR 405.000, and with prior authorization.

In addition to an EPSDT visit, the Plan will reimburse the add-on code S0302 when all components of an EPSDT have been performed.

Vaccine administration is separately payable with an EPSDT visit.

Audiometric hearing tests (CPT 92551, 92552) and vision tests (CPT 92587, 99173) are separately reimbursed with an EPSDT visit.

Community Health Center Manual, Subchapter 6, Section 609 lists the service codes that are payable under MassHealth for EPSDT visits (99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395).

See 130 CMR 450.140 through 450.149 for other requirements

Evaluation and management visits
Subchapter 6 Section 604(B) lists evaluation and management visit service codes that are payable when billed by a CHC.

The vaccine administration service codes listed in Subchapter 6 Section 604(C) are payable in addition to the evaluation and management visit service codes in Subchapter 6 Section 604(B), provided that the vaccine administration is a medically necessary, separately identifiable service. Under these circumstances, the CHC may append modifier 25 to the evaluation and management visit service code.

The CHC may bill for a 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 (130 CMR 405.421(G)). An evaluation and management visit service code listed in in Section 604(B), will deny if billed on the same date of service as T1015. Modifier 25 will not override the denial.

HIV pre- and post-test counseling visits
CHCs may bill and receive payment for two HIV pre-test counseling visits before HIV testing and two HIV post-test counseling visits after HIV testing, when provided to a plan member by a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, registered nurse, or counselor (working under the supervision of one of the aforementioned). CHCs must use CPT 99402 to bill for HIV pre- and post-test counseling visits. A maximum of four pre-test counseling visits and four post-test counseling visits per calendar year per member are reimbursable.

HIV pre-test counseling visit
A face-to-face meeting at the CHC between the member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling before HIV testing. Providers will offer information on risk factors and implications of both positive and negative test results, in accordance with established protocols of the Massachusetts Department of Public Health (130 CMR 405.402).

HIV post-test counseling visit
A face-to-face meeting at the CHC between the member and a physician, physician assistant, certified nurse practitioner, clinical nurse specialist, registered nurse, or counselor (working under the supervision of one of the aforementioned) for the purpose of providing counseling after HIV testing. Such counseling will include information about the implications of positive and negative test results, risk-reduction techniques, partner notification, and referral to medical and support services, in accordance with established protocols of the Massachusetts Department of Public Health (130 CMR 405.402).

Obstetric services
The Plan reimburses two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available for covered obstetric services. The global-fee method is available only when the conditions in 130 CMR 405.423 are met.

Global Fee Method of Payment (CPT 59400, 59510, 59610, 59618)
Definition of global fee – The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The global fee is available only when the conditions in 130 CMR 405.423 are met.

Conditions for global fee – Only the CHC may claim payment of the global fee. To qualify to receive a global fee payment, the CHC must coordinate a minimum of six prenatal visits, the delivery, and postpartum care, provided by a physician, a nurse, a certified nurse practitioner, a certified nurse midwife, or a physician assistant who is qualified to perform such services and is a contractor or employee of the CHC. Such an employee or contractor must not be receiving a salary from a hospital or institution to perform the same service. For example, if a staff physician from a hospital performs a delivery while on hospital salary for that service, the CHC must not bill for the global fee for that delivery, but may bill fee for service for the medical visits. However, those visits are not covered if provided by someone receiving a hospital or institutional salary to perform the same service.

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

Multiple providers – When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.
(1) The global fee may be claimed only by the CHC and only if the required services (minimum of six prenatal visits, the delivery, and postpartum care) are provided directly by a physician, a nurse, a certified nurse practitioner, a certified nurse midwife, or a physician assistant who is qualified to perform such services and is a contractor or employee of the CHC.
(2) If the CHC bills for the global fee, any provider who is not a contractor or employee of the CHC, but who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the CHC bills for the global fee, no other provider may claim payment for the delivery.
(3) If the CHC bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same member.

Fee-for-service method of payment (CPT 59409, 59410, 59414, 59514, 59515, 59525, 59612, 59614, 59620, and 59622)
The fee-for-service method of payment is always available to a provider for obstetric services covered by the Plan. If the global fee requirements in 130 CMR 405.423 are not met, the provider or providers may claim payment from the Plan only on a fee-for-service basis, as specified in 130 CMR 405.426 (A) and (B).

(A) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.
(B) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

Hysterectomy services
The Plan does not pay for a hysterectomy provided to a member under the following conditions. (1) The hysterectomy was performed solely for the purpose of sterilizing the member. (2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

The Plan pays for a hysterectomy only when performed by a licensed physician in a hospital, and the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified in 130 CMR 405.424(B)(1) through (4).

Certified nurse-midwife services
The CHC may bill for services provided by a certified nurse midwife that relate to pregnancy, labor, birth, and the immediate postpartum period when the nurse midwife is a contractor or employee of the CHC. The following conditions also apply.
(1) The services must be limited to the scope of practice authorized by state law or regulation.
(2) The certified nurse midwife must meet the educational and certification requirements mandated by state law or regulation.
(3) The certified nurse midwife must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.
(4) The immediate postpartum period during which certified nurse-midwife services may be provided is defined as a period of time not to exceed six weeks after the date of delivery.
(5) Deliveries by a certified nurse midwife must occur in facilities licensed by the Department of Public Health for the operation of maternity and newborn services.

Nonpayable services
(1) Childbirth education classes are not payable.
(2) Prenatal or postpartum care provided by a certified nurse midwife in the member's home is not payable.

A certified nurse midwife on the staff of a CHC must have successfully completed a formal educational program for certified nurse midwives as required by the Massachusetts Board of Registration in Nursing and meet all Education and Certification requirements in 405.427 (C).

Sterilization services
The Plan pays for a sterilization service provided to an eligible member only if all of the following conditions are met.
(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 405.429, and such consent is documented in the manner and form described in 130 CMR 405.430.
(2) The member is at least 18 years old at the time consent is obtained.
(3) The member is not a mentally incompetent individual or an institutionalized individual.

Locations in Which Sterilizations May Be Performed: (1) Male sterilization must be performed by a licensed physician at the CHC. (2) Female sterilization must be performed by a licensed physician in a hospital. (3) A hospital in which a sterilization is performed must be licensed in compliance with 105 CMR 130.000: Hospital Licensure.

A member’s consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 405.429 (A) and (B), and such consent is documented as specified in 130 CMR 405.430.

Laboratory services
The Plan pays CHCs for laboratory service codes listed as payable in Subchapter 6 of the Community Health Center Manual on the date of service.

Some laboratory services require prior authorization as a prerequisite for payment.

The Plan pays a CHC 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 405.000, and 450.000: Administrative and Billing Regulations.

In order for a CHC 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.

A CHC may claim payment for the laboratory services listed in Subchapter 6 of the Community Health Center Manual only when all of the following conditions are met.

(A) The laboratory services are performed in the CHC.
(B) The laboratory tests are performed on properly and regularly calibrated equipment, and daily controls are carried out.
(C) The CHC 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 CHC'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 CHC 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 CHC is located in-state, the CHC has been approved by the Massachusetts Department of Public Health to perform in-house clinical laboratory services. If the CHC is located out-ofstate, in addition to meeting the requirements of 130 CMR 405.404(B), 405.432 (A) through (C), and 450.109: Out of State Services, the CHC must also meet its own state's requirements for performing in-house clinical laboratory services.

Laboratory service limitations

The Plan will not pay a CHC for services listed as non-covered services or for which payment limitations apply in accordance with the MassHealth Independent Clinical Laboratory Manual at 130 CMR 401.000: Independent Clinical Laboratory.

The Plan will not pay a CHC 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).

The Plan does not pay a CHC for the professional component of a clinical laboratory service. The Plan will pay a CHC for the professional component of an anatomical service, as provided in Subchapter 6 of the Community Health Center Manual (for example, bone marrow analysis or analysis of a surgical specimen).

In no event may a CHC 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 CHC or requested by an authorized person.

The Plan 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.

A CHC may not bill for a visit when a member is being seen for laboratory services only (130 CMR 405.433 (G)).

Services performed by outside laboratories

A CHC may not bill the Plan for laboratory services provided outside the CHC. In this case, the testing laboratory should bill the Plan directly for those services.

Definitive drug testing billed on the same date of service as presumptive drug testing for MassHealth ACO members

MassHealth has established claim edits for quantitative drug tests billed on the same date of service as a drug screen service effective for dates of service on or after January 1, 2013.

Effective for dates of service beginning on January 1, 2016, CHCs are instructed to bill for quantitative drug testing using the following codes: G0480, G0481, G0482, G0483 (*Source: MassHealth Transmittal Letter CHC-106 July 2016*).

Effective for dates of service beginning on January 1, 2017, CHCs are instructed to bill drug screening using the following new codes for presumptive drug testing; CPT 80305, 80306, 80307 (*Source: MassHealth Transmittal Letter CHC-109 April 2017*).

In accordance with MassHealth, quantitative (definitive) drug tests (G0480, G0481, G0482, G0483) billed on the same date of service as a drug screen service (presumptive) (80305, 80306, 80307) for MassHealth ACO members will be denied.

Radiology services
The Plan will pay for the radiology services listed in Subchapter 6 of the Community Health Center Manual when the services are Medically Necessary and provided at the written request of a licensed physician or dentist.

High technology radiology services provided in the elective, outpatient setting, require prior authorization. The ordering provider is responsible for obtaining prior authorization.

Payment of the global fee
The Plan will pay a CHC the global fee for performing a radiology service at the CHC when one of the following conditions is met.
(1) The CHC 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 CHC employs a board-certified or board-eligible radiologist to provide the professional component of the service and the CHC subcontracts with a licensed Medicarecertified entity to provide the technical component of the service.
(3) The CHC subcontracts with a licensed Medicare-certified entity to provide the professional and technical component of the service.

A CHC must not bill for either the professional or technical component separately.

Radiology services that are not listed in Subchapter 6 of the Community Health Center Manual are not reimbursable when furnished in a CHC. The CHC should refer a member to a hospital for such services.

A CHC must not bill for a visit when a member is being seen for a radiology service only (130 CMR 405.433(D).

Breast cancer screening for MassHealth ACO members
Chapter 231 of the Acts of 2024 amends Massachusetts General Laws Chapter 118, adding section 10W (applicable to MassHealth ACO members). Section 10W adds coverage for Medically Necessary and appropriate breast cancer screening with breast magnetic resonance imaging (MRI) or screening breast ultrasound as an alternative to screening mammograms (with or without digital breast tomosynthesis), effective for dates of service on or after January 1, 2026.

- Breast magnetic resonance imaging (MRI) is billed with CPT 77046, 77047, 77048 or 77049. Screening breast MRI must be reported with ICD-10 diagnosis code Z12.39. Note: Prior authorization is required for high-tech radiology including screening breast MRI.
- Breast ultrasound is billed with CPT code 76641 or 76642. Both of these codes are unilateral. To report bilateral breast ultrasound, append modifier 50. Screening breast ultrasound must be reported with ICD-10 diagnosis code Z12.39.

Surgery services
The Plan will pay CHCs for the surgery services listed in Subchapter 6 Section 606 of the Community Health Center Manual when the surgery services are medically necessary.

Some surgery services require prior authorization as a prerequisite for payment.

The CHC may bill for a 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. Examples of treatments or procedures are a vasectomy, colposcopy, or an amniocentesis (130 CMR 405.421(F)). The Plan will deny a surgery service when billed with an individual medical visit.

Electrocardiogram (EKG) Services
The Plan will pay for an electrocardiogram (EKG) service only when the service is provided at the written request of a CHC staff physician who will interpret or review the interpretation of the EKG.

Documentation of the physician's request must be kept in the member's medical record.

The maximum allowable fees include payment for both the technical and professional components of the service. The test must be performed at the CHC and interpreted by a physician employed by the CHC.

A CHC must not bill for a visit when a member is being seen for an EKG only (130 CMR 405.453(B).

Audiology services
In order for a CHC to be paid for an audiology service other than a hearing test performed as part of an EPSDT services assessment (see 130 CMR 450.140 through 450.149), a written request must be made by a physician, physician assistant, or certified nurse practitioner who has found some indication of a hearing problem. Documentation of the request and of the hearing problem must be kept in the member's medical record.

A CHC may claim payment for a basic pure-tone (air and bone) evaluation by audiometer furnished to a member only when the following conditions are met.
(1) The CHC possesses on its premises a pure-tone audiometer, which must be calibrated at least once every six months. Records of calibrations must be kept and made available to the MassHealth agency upon request. The machine must be placed and testing conducted in a quiet room.
(2) The person conducting hearing evaluations is trained to perform hearing tests with an audiometer.
(3) The quality of the tester's work is assessed at least twice a year by an audiologist licensed or certified in accordance with 130 CMR 426.404: Provider Eligibility. The audiologist may be a consultant to the CHC.

A CHC may claim payment for conducting acoustic impedance testing only when the following conditions are met.
(1) The test is conducted by an ASLHA-certified audiologist on the premises of the CHC.
(2) The test is conducted by means of a functioning impedance bridge that is placed in a quiet room.

If a problem or abnormality is detected or believed to be present after completion of either the basic pure-tone evaluation or the acoustic impedance test or both, the member must be referred to an otologist or an otolaryngologist for a more complete audiological evaluation and treatment as necessary.

Audiology services that are not listed in Subchapter 6 of the Community Health Center Manual are not reimbursable when furnished in a CHC.

Payable audiology service codes:
a. Screening test, pure tone, air only: 92551
b. Pure tone audiometry (threshold); air only: 92552
c. Pure tone audiometry (threshold); air and bone: 92553
d. Tympanometry (impedance testing): 92567

A CHC must not bill for an office visit when a member is seen for audiology services only (130 CMR 405.463 (B)).

Drugs administered in the CHC (provider-administered drugs)
Drugs and biologicals dispensed in the CHC are payable, subject to the exclusions and service limitations at 130 CMR 405.417, 405.418, and 130 CMR 406.413(B): Drug Exclusions and (C): Service Limitations.

The Plan does not pay separately for drugs that are considered routine and integral to the delivery of a service in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the CHC's fee for the service.

The Plan does not pay separately for any oral drugs dispensed in the office for which the CHC has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals.

Claims for drugs and biologicals that are listed in Section 604 Subchapter 6 of the Community Health Center Manual must include the name of the drug or biological, strength, dosage, and number of Healthcare Common Procedure Coding System (HCPCS) units dispensed, National Drug Code (NDC), NDC units, and NDC unit of measurement.

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

The Plan does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.

Payment for drugs may be claimed in addition to an office visit (130 CMR 405.468(G).

Payable drug codes are listed in Subchapter 6, Section 604(E) of the Community Health Center Manual.

Tobacco-cessation counseling services
MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 405.472(B) and pharmacotherapy treatment, including nicotine replacement therapy, in accordance with 130 CMR 406.000: Pharmacy Services.

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

(a) Individual counseling consists of face-to-face tobacco-cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobaccocessation services as set forth in 130 CMR 405.472 (B) and (C).
(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members, and has a duration of at least 60 to 90 minutes.
(c) Individual and group counseling also includes collaboration with and facilitating referrals to other healthcare providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

Refer to 130 CMR 405.472 (B) (2) for a description of what must be included in tobacco-cessation counseling services.

<u>Provider qualifications for tobacco-cessation counseling services</u>
Qualified Personnel:

(a) Physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants may

provide tobacco-cessation counseling services without additional experience or training in tobacco-cessation counseling services.

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

Supervision of tobacco-cessation counseling services

A physician must supervise all nonphysician providers of tobacco-cessation counseling services..

A CHC may submit claims for tobacco-cessation counseling services that are provided by physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists and physician assistants, and MassHealth-qualified tobacco-cessation counselors according to 130 CMR 405.472 (B) and (C).

The CHC may bill for a 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. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit (130 CMR 405.421 (F)).

See Billing/coding guidelines for payable service codes and modiiers for tobacco-cessation counseling services furnished by CHCs.

Medications for tobacco cessation, such as nicotine replacement therapy, are covered under the pharmacy/prescription drug benefit. MassHealth members must present the prescription to their pharmacy in order for the cost of the medications to be covered by the Plan.

Fluoride varnish services

Oral health education, fluoride varnish and fluoride supplementation are three aspects of oral health that are addressed by both primary care providers and dental providers. In accordance with Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules, tfluoride he need for fluoride varnish should be assessed at all preventive visits from 6 months to 5 years old. Once teeth are present, fluoride varnish may be applied to the child every 3 to 6 months in the primary care or dental office.

CHCs may bill for fluoride varnish services provided by qualified personnel to EPSDT-eligible MassHealth members in accordance with 130 CMR 405.473: Fluoride Varnish Services.

130 CMR 405.473(B) defines qualified personnel. Qualified personnel include physicians and physician assistants, certified nurse practitioners, registered nurses, licensed practical nurses, and medical assistants under the supervision of a physician and employed by the CHC.

In MassHealth Community Health Center Bulletin 118 (July 2023), MassHealth added community health workers under the supervision of a physician and employed by the CHC to the list of qualified personnel who may apply fluoride varnish.

To qualify to apply fluoride varnish, qualified personnel must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of training, and provide such proof to the Plan upon request..

In MassHealth Community Health Center Bulletin 121 September 2023, to , MassHealth removed the requirement that qualified personnel must complete a MassHealth-approved training for fluoride varnish services. CHCs may decide which training fits the context and requirements of their unique health care setting. MassHealth will continue to provide Fluoride Varnish Training for Health Care Professionals as a resource for MassHealth providers.

CHCs must use CPT 99188 to report the application of topical fluoride varnish by qualified personnel.

Transmittal Letter ALL-252 (August 2025) updates Appendix W and Appendix Z of the MassHealth Provider Manuals. Effective for dates of service on or after August 19, 2025, when billing for fluoride varnish treatment provided to an EPSDT-eligible MassHealth member during a well-child visit (CPT 99381-99385 and 99391-99395) CHCs must bill the CPT code 99188 and ICD-10 code Z00.129, Routine Child Health Check. When billing for fluoride varnish treatment provided during any other visit, CHCs must bill CPT code 99188 and ICD-10 code Z41.8, Need for Prophylactic Fluoride Administration.

The CHC may bill for a medical visit in addition to fluoride varnish application only if fluoride varnish application was not the sole service, treatment, or procedure provided during the visit (130 CMR 405.473(C).

The dental enhancement fee (D9450) may not be billed for a fluoride varnish application separately or in addition to a medical visit.

Acupuncture services
MassHealth members are eligible to receive acupuncture services in CHCs for the treatment of pain as described in 130 CMR 405.474(C).

The Plan covers a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may be able to receive more sessions of medically-necessary acupuncture treatment with prior authorization.

Provider Qualifications for Acupuncture
The Plan pays a CHC for acupuncture services only when the provider rendering the service is:
(a) a physician; or
(b) licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: The Practice of Acupuncture.

CHCs must ensure that acupuncture providers for whom the CHC will submit claims possess the appropriate training, credentials, and licensure.

The Plan pays the CHC for services of an acupuncturist qualified to render such services in accordance with 130 CMR 405.474 (D) only when:
(1) the services are limited to the scope of practice authorized by state law or regulation (such as 243 CMR 5.00: The Practice of Acupuncture); and
(2) the provider has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine.

Community health centers (CHCs) may submit claims for acupuncture services when a provider qualified to render such services in accordance with 130 CMR 405.474(D) provides those services directly to MassHealth members.

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

Medical nutrition therapy
MassHealth members are eligible to receive medical nutrition therapy services described in 130 CMR 405.475(B).

Medical nutritional therapy is nutritional diagnostic therapy and counseling services for the purpose of management of a medical condition.

Medical nutrition therapy services are payable when provided to eligible MassHealth members by the following providers:
(1) physicians;

(2) dietitians/nutritionists licensed by the Massachusetts Division of Professional licensure, and the Board of Registration of Dietitians and Nutritionists;
(3) mid-level practitioners credentialed by the Commission on Dietetic Registration (CDR) (e.g., certified nurse-midwives, certified nurse practitioners, registered nurses, and physician assistants); or
(4) other health-care providers licensed by the Massachusetts Division of Professional Licensure, and the Board of Registration of Dietitians and Nutritionists, with specific training in the provision of nutritional counseling as provided in 42 U.S.C. 1395x(vv)(2)

Diabetes self-management training
MassHealth members are eligible to receive diabetes self-management (DSMT) training services described in 130 CMR 405.476(B).

Diabetes self-management training is diabetes self-management training and education, which may include medical nutrition therapy, and are furnished to an individual with pre-diabetes or diabetes.

(B) The MassHealth agency pays for DSMT and education, which may include medical nutrition therapy, and are furnished to an individual with pre-diabetes or diabetes. DSMT services are payable when provided to eligible MassHealth members by the following providers:
(1) physicians;
(2) dietitians/nutritionists licensed by the Massachusetts Division of Professional Licensure, and the Board of Registration of Dietitians and Nutritionists;
(3) mid-level practitioners credentialed by the National Certification Board of Diabetes Educators (NCBDE) (e.g., nurse-midwives, nurse practitioners, registered nurses, and physician assistants); or (4) other health-care practitioners with specific training in the provision of DSMT as provided in 42 U.S.C. 1395x(qq)(2).

Medication therapy management and collaborative drug therapy management
Source: *MassHealth Transmittal Letter CHC-118 January 2022*
Medication Therapy Management (MTM) is a service provided by a licensed clinical pharmacist employed by a community health center in connection with a visit for the purpose of optimizing drug therapy with the intent of improving therapeutic outcomes for patients. MTM includes patient assessment, comprehensive medication review, formulation of a medication treatment plan, monitoring safety and efficacy of medications, and improving drug adherence. Any changes in medications recommended through MTM must be made directly by or in collaboration with the primary care clinician.

Collaborative Drug Therapy Management (CDTM) is a service provided by a qualified CDTM pharmacist employed by a community health center in connection with a visit for the purpose of performing clinical services under the protocols established by the community health center under a collaborative practice agreement (CPA). A qualified CDTM pharmacist is one who meets the qualifications and criteria under 247 CMR 16.00 and is approved by the MassHealth community health center program. CDTM includes performing patient assessments, counseling, referrals, ordering laboratory tests, administering drugs, and selecting, initiating, monitoring, continuing, and adjusting drug regimens.

CPT 99605, 99606 and 99607 should used for billing MTM and CDTM. Visit limits apply.

Behavioral health integration
Source: *MassHealth Transmittal Letter CHC-118 January 2022*
Behavioral health integration (BHI) is a service provided under the direction of a primary care provider by a mental or behavioral health clinician with, at a minimum, masters-level training in mental or behavioral health for at least 20 minutes per month per patient, for the purpose of (i) providing an initial behavioral health assessment, including the use of applicable validated rating scales, and behavioral health monitoring; (ii) developing a behavioral health treatment plan; and (iii) facilitating and coordinating treatment.

BHI services are delivered to patients who have a continuous relationship with an integrated primary care team consisting of the primary care provider and the masters-level mental or behavioral health clinician providing the service.

BHI services may not also be billed as CoCM services.

Collaborative care management
Source: *MassHealth Transmittal Letter CHC-118 January 2022*
Collaborative Care Management (CoCM) is a service provided under the direction of a primary care provider. The rendering provider on claims for BHI must be the member's primary care provider , and in consultation with a psychiatrist or an advanced practice registered nurse (APRN) with a graduate degree and advanced training in psychiatric care (a psychiatric clinical nurse specialist or a psychiatric mental health nurse practitioner), by a behavioral health care manager who is a mental or behavioral health clinician with, at a minimum, masters-level training in mental or behavioral health.

CoCM services are provided for at least 70 minutes per patient in the first month of CoCM services to such patient, and at least 60 minutes per month for such patients after their first month receiving CoCM services. CoCM services are provided for the purpose of (i) providing an initial behavioral health assessment, including the use of applicable validated rating scales, and behavioral health monitoring; (ii) developing a behavioral health treatment plan; (iii) facilitating and coordinating treatment, including referrals; (iv) providing proactive and systematic follow-up by the behavioral health care manager; and (v) providing regular case review with the consulting psychiatric clinician.

CoCM services are delivered to patients who have a continuous relationship with an integrated primary care team, consisting of the primary care provider, the behavioral health care manager, and the consulting psychiatric clinician, that meets at least weekly to review the patient's treatment plan and status and make adjustments or referrals to specialty care, as needed.

CoCM services may not also be billed as BHI services.

Remote patient monitoring
Source: *MassHealth Transmittal Letter CHC-122 July 2024*
Effective August 1, 2024, MassHealth members who meet certain criteria are eligible for remote patient monitoring (RPM). MassHealth defines RPM as the use of select medical devices that transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location. The information is generated so the provider can respond to the patient and manage their condition.

RPM does not apply to Continuous Glucose Monitoring (CGM) devices, Holter monitors, implantable pacemakers and defibrillators, or electroencephalograms.

Coverage criteria

The Plan provides coverage for RPM when the following criteria are met.

1. Eligible conditions

The member must have one of the following conditions:
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Diabetes Type I or II
- Hypertension
- Perinatal state (defined as the period encompassing pregnancy, labor, and delivery, through 12 months following delivery, inclusive of all pregnancy outcomes)

2. Patient criteria
    a. For eligible conditions other than the perinatal state, the member's condition(s) must demonstrate instability or risk for deterioration as evidenced by either

- a history of more than two hospitalizations or Emergency Department (ED) visits for the same qualifying condition (or for related conditions) over the past 24 months, or
- presence of factors suggesting the member is at risk for ED or hospitalization (for example, recent discharge from inpatient stay or extended stay in a setting such as a Skilled Nursing Facility, documented poor adherence to ordered medication, or a documented history of care access challenges such as consistently missed appointments), as determined by the ordering provider.

b. For the perinatal state, the provider recommending RPM should identify one or more risk factors that warrant the use of RPM. The following is a non-exhaustive list of risk factors for gestational hypertension and preeclampsia.
   - Nulliparity
   - Multifetal gestation
   - Preeclampsia in a previous pregnancy
   - Chronic hypertension o Pregestational diabetes
   - Gestational diabetes
   - Thrombophilia
   - Systemic lupus erythematosus
   - Pregnancy body mass index greater than or equal to 30
   - Antiphospholipid antibody syndrome Kidney disease
   - Assisted reproductive technology
   - Obstructive sleep apnea

   Comprehensive assessment of risk should be based on clinical judgment and may include consideration of social and demographic factors.

3. Provider requirements
   - RPM services may be provided by the following provider types: physician, nurse practitioner (NP), certified nurse specialist (CNS), physician assistant (PA), certified nurse mid-wife (CNM).
   - For new patients or patients not seen by the practitioner within one year, the practitioner must first conduct a face-to-face or telehealth visit with the patient to initiate RPM.
   - Providers billing RPM services must have policies and systems in place to ensure timely and appropriate responses to emergent, urgent, and routine member needs related to use of remotepatient monitoring (such as monitoring data outside of expected parameters).
   - Providers should ensure that they work with other providers as necessary for care coordination.
4. Technology Criteria
   - Devices used for RPM may include, but are not limited to, devices that monitor blood pressure, oxygenation, and weight. Coverage of RPM does not apply to continuous glucose monitoring (CGM) devices, Holter monitors, implantable pacemakers and defibrillators, or electroencephalograms.
   - Devices must be capable of automatic reporting compatible with Medicare requirements (for example, the device automatically transmits biomonitoring data to the provider) without the member needing to manually report the data.
   - Some providers may use RPM through a vendor who assists with management of RPM devices. However, billing must be done by the MassHealth-enrolled provider.
   - To bill for CPT code 99454, the member must get the device from the provider, not through the durable medical equipment supplier or pharmacy. Providers can only bill for the device once it has been given to an eligible member.
5. Security criteria

- All services must meet the minimum federal and state requirements for protecting patient privacy and security, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by RPM, including the actual transmission of health care data and any other electronic information/records.
- All devices must be FDA-approved as a medical device.

EPSDT parent and caregiver depression, developmental, or autism spectrum disorder screening
Effective November 21, 2024, Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules and Appendix Z: EPSDT/PPHSD Screening Services Codes of the MassHealth Provider Manuals were updated (*Source: MassHealth Transmittal Letter ALL-249 November 2024*).

Screening the child's parent(s) or caregiver(s) for postpartum depression should now occur at every preventive pediatric visit from the one month visit to the twelve month visit.

Pediatricians and pediatric providers must use CPT 96110 and modifiers U1, U2, U3, U4 and UG, as applicable, for Parent and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening.

Note: Parent and Caregiver Depression Screening is billed using the child's member ID.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified.
U3 - No follow-up needed
U4 - Follow-up needed
UD - Administration and scoring of a standardized screening tool for parent and caregiver postpartum depression (used in combination with U1 or U2)

Behavioral health assessment and depression screening
Effective November 21, 2024, Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules and Appendix Z: EPSDT/PPHSD Screening Services Codes of the MassHealth Provider Manuals were updated (*Source: MassHealth Transmittal Letter ALL-249 November 2024*).

Providers must use CPT 96127 and modifier U1 or U2, as applicable for Behavioral Health Assessment and Depression Screening.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified.

Perinatal depression screening
Source: MassHealth All Provider Bulletin 405

Effective for dates of service beginning August 19, 2025, MassHealth covers all perinatal depression screenings that occur during pregnancy through 12 months following the end of the pregnancy, inclusive of all pregnancy outcomes, as clinically appropriate. MassHealth covers one perinatal depression screening per member per date of service. Such depression screenings must be billed using the perinatal member's MassHealth ID number and modifier U1 or U2 as applicable (MassHealth All Provider Bulletin 405 August 2025).

MassHealth recommends that obstetricians and gynecologists screen for perinatal depression at the initial prenatal visit, later in pregnancy, and at postpartum visits at a minimum.

MassHealth requires primary care providers, obstetricians, gynecologists, and certified nurse midwives to offer postpartum depression screening to members during the 12 months following the end of pregnancy and take certain actions for positive screens.

For those patients who have a positive screen for depression, providers should discuss available treatments for perinatal depression or major depressive disorder, including pharmacological options, and a referral to a mental health clinician, when clinically appropriate,

Service Code S3005 is used for the performance measurement and evaluation of patient self-assessment and depression. S3005 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
UD Perinatal Care Provider – Depression Screen: completed prenatal or postpartum

Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids program

CARES for Kids Program (CARES program) is a targeted case management (TCM) service for eligible high risk individuals under age 21 with medical complexity. The CARES program is rendered by CARES program providers certified in accordance with 130 CMR 405.477(D). The MassHealth provider types eligible to participate in the CARES program are:

- Community health centers (CHC)
- Acute outpatient hospitals (AOH)
- Group practices

To receive CARES program services, a member must meet criteria in 130 CMR 405.77(C).

In order to participate in the CARES program and receive reimbursement for providing CARES services, a CHC must become certified and meet requirements in 130 CMR 405.477(A) through 405.477(H). To be considered for certification to render CARES services, a MassHealth CHC, AOH, or group practice must submit the CARES Program Provider Certification Form to CARES@mass.gov for MassHealth consideration.

The term “CARES program requirements” refers to all requirements described in MassHealth All Provider Bulletin 370 (June 2023) and in the regulations to be promulgated on July 7, 2023, at 130 CMR 405.477: CARES Program Services.

The provider’s CARES team will be primarily responsible for:

- facilitating and improving the care planning and coordination of services for eligible medically complex MassHealth members younger than 21 years of age; and
- providing a single point of accountability for ensuring that necessary medical, educational, social, or other services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, culturally competent, linguistically appropriate, and accessible manner.

The Plan will reimburse an eligible CARES program provider for CARES program services only if the member receiving CARES program services is eligible to receive such services under 130 CMR 405.477(C).

The CARES program provider must ensure that CARES program services are provided only by individuals serving on the CARES team who are qualified to render such services. Detailed service components are outlined in Appendix M of the Physician Manual. CARES program services must include at a minimum:

- A comprehensive assessment and periodic reassessment of the member at least once a year
- Development of an individual care plan (ICP) with goals

- Care coordination and family support activities

The Plan will make a singe monthly payment for all CARES program services rendered by a CARES program provider to an eligible member during that calendar month. In order to qualify for payment of the monthly fee, the CARES program provider must provide at least two of the CARES program services described in the regulation to that member during that calendar month, with at least one of those services including live interaction between the provider and the member and their parent/guardian, whether in person or via telehealth. A CARES program provider may not bill the Plan the monthly fee for any calendar month in which the provider renders only one of the services described in the regulation to the member.

If the member assigned to a CARES program provider is admitted to a nursing facility or other inpatient facility during the period of assignment, the MassHealth agency pays for CARES program services rendered by that CARES program provider to that member for up to six consecutive months from the date of admission, subject to compliance with all applicable requirements in 130 CMR 405.477(A) through 405.477(H) and Appendix M of the Physician Manual. MassHealth will not pay for CARES program services rendered to any member who has resided in a nursing facility or other inpatient facility for more than six consecutive months.

The Plan will not pay for more than one TCM service per member for the same dates of service, whether that TCM service is through the CARES program or a different TCM covered service.

Annual behavioral health wellness examinations for MassHealth ACO members
Through All Provider Bulletin 392, effective July 1, 2024, MassHealth began covering annual behavioral health wellness examinations provided by primary care providers or licensed mental health professionals with no member cost-sharing.

The annual behavioral health wellness examination includes a screening or assessment to identify any behavioral or mental health needs and the appropriate resources for treatment. For an overview of the components of this annual behavioral health wellness examination, providers should refer to Appendix A of the Division of Insurance Bulletin 2024-02, which is incorporated here by reference and applicable to providers rendering the annual behavioral health wellness examination as a MassHealth service.

Effective September 23, 2025, All Provider Bulletin 408 updates the guidance and requirements for billing annual behavioral wellness examinations. When the annual behavioral health wellness examination is performed by a community health center, the following billing requirements apply.

<u>Billing guidance for the Annual Behavioral Health Wellness Examination performed by a licensed mental health professional</u>:

- Effective September 23, 2025, when the Annual Behavioral Health Wellness Examination is rendered by licensed clinical social workers, licensed mental health counselors, licensed marriage and family therapists, or psychologists, the CHC should bill:
  - Procedure code T1040, with
  - Diagnosis code Z13.30.
- Effective September 23, 2025, when the Annual Behavioral Health Wellness Examination is rendered by a psychiatrist or advance practice registered nurse specializing in psychiatry, the CHC should bill:
  - Procedure code G0469 or G0470, with
  - Diagnosis code Z13.30.

This guidance applies when a licensed mental health professional at a CHC performs the annual behavioral health wellness examination, whether rendered as a standalone service or on the same day as a primary care visit. An unlicensed mental health professional is not qualified to render an annual behavioral health wellness examination. When the Annual Behavioral Health Wellness Examination is performed by a licensed mental health professional, the claim must be submitted to the Plan's behavioral health vendor.

Billing guidance for the Annual Behavioral Health Wellness Examination performed by a primary care provider who is not a licensed mental health professional:

- When the Annual Behavioral Health Wellness Examination is rendered independently of other CHC services by a primary care provider qualified to provide an individual medical visit, as such term is defined in 101 CMR 304.00: *Rates for Community Health Centers*, the CHC should bill:
  - Procedure code T1015, with
  - Diagnosis code Z13.30.
- Effective September 23, 2025, when the Annual Behavioral Health Wellness Examination is rendered as part of a primary care visit, the CHC should bill:
  - Procedure code T1015, and
  - Procedure code 90791, with
  - Diagnosis code Z13.30.

Diagnosis code Z13.30 must be included in the claim in order to receive payment for procedure code 90791.

When billing procedure code 90791 with a primary diagnosis of Z13.30 to indicate an annual behavioral health wellness examination, providers do not need to conduct a Child and Adolescent Needs and Strengths (CANS) assessment for members younger than 21 years of age.

The Plan will pay for only one annual behavioral health wellness examination per member per year.

Referral/notification/prior authorization requirements

Unlisted codes require prior authorization (e.g., CPT 84999, 85999, 86849, 87999, 88199, 88399, 93799).

Some laboratory services including genetic testing require prior authorization.

High-tech radiology services provided in the elective, outpatient setting, require prior authorization. Fallon Health partners with eviCore to provide authorization services for high-tech outpatient elective diagnostic imaging procedures for your patients. Authorization is required for CT scans (including CTA), MRI/MRA studies, Nuclear Cardiac Imaging (NCM), and PET scans.

Mobile cardiac telemetry (CPT 93228, 93229) requires prior authorization.

Billing/coding guidelines

The Plan requires all professional charges to be submitted on a CMS-1500 claims form and hospital charges to be submitted on a UB-04 claims form, or in HIPAA-standard electronic formats, per industry standard guidelines.

CHCs should submit claims for community health center encounters on a professional claim form (CMS-1500), or the electronic equivalent (837P).

CHCs should report the Place of Service (POS) code 50 for community health center encounters.

CHCs should report the POS Code 02 or 10 when services are delivered via telehealth.

Fallon Health does not require “supporting codes” on claims with T1015. Supporting codes must not be included on claims submitted by CHCs. Supporting codes may also be referred to as qualifying vist codes.

Claims for CHC services provided by physicians, nurse practitioners (NP), certified nurse specialists (CNS), physician assistants (PA), certified nurse mid-wifes (CNM) or pharmacists must be billed with the name and NPI of the rendering physician, NP, CNS, PA, CMN or pharmacist. The Pay-to Entity on the claim must be the CHC.

Rendering Provider: This refers to the specific healthcare professional who provided the service to the patient.

Pay-to Entity: This is the entity that will receive the payment for the rendered service.

The Plan applies industry standard claims edits.

Modifier 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, is used when distinct services are performed on the same day. Modifier 25 should only be appended to E/M services codes.

All-inclusive individual medical visit

- CHCs that bill for an individual medical visit must ensure that the visit amounts to an individual medical visit as defined under 130 CMR 405.402: Definitions.
- Refer to 130 CMR 405.421 for restrictions and limitations that apply to visits as defined in 130 CMR 405.402.

CPT Code	Description
T1015	Clinic visit/encounter, all-inclusive (Use for all-inclusive individual medical visit)
T1015 TH	Clinic visit/encounter, all-inclusive (Use for all individual medical visits with a certified nurse midwife or obstetrician gynecologist effective November 1, 2025)

Annual behavioral health wellness examinations for MassHealth ACO members

Effective September 23, 2025

- When the Annual Behavioral Health Wellness Examination is rendered independently of other CHC services by a primary care provider qualified to provide an individual medical visit, as such term is defined in 101 CMR 304.00: Rates for Community Health Centers, the CHC should bill:
  - Procedure code T1015, with
  - Diagnosis code Z13.30.
- When the Annual Behavioral Health Wellness Examination is rendered as part of a primary care visit, the CHC should bill:
  - Procedure code T1015, and
  - Procedure code 90791, with
  - Diagnosis code Z13.30.

CPT Code	Description
90791	Psychiatric diagnostic evaluation (an integrated biopsychosocial assessment, including history, mental status, and recommendations) (Use for Annual Behavioral Health Wellness Examinations for MassHealth ACO Members rendered as part of a primary care visit)

Therapeutic, prophylactic, and diagnostic injections and infusions (excludes chemotherapy)

The CHC may bill for a 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. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit. Examples of treatments or procedures are a vasectomy, colposcopy, or an amniocentesis. X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit (130 CMR 405.421 (F)). The Plan will deny a surgery service when billed with an individual medical visit.

CPT Code	Description
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour

96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substatnce or drug), subcutaneous or intramuscular

Vaccine administration

- Vaccine administration is not separately payable when billed with an individual medical visit (T1015) (MassHealth Community Health Center Bulletin 109 May 2021).
- Vaccine administration is separately payable with an EPSDT visit.
- The vaccine administration service codes listed in Section 604(B) are payable in addition to the evaluation and management visit service codes in Section 604(B), provided that the vaccine administration is a Medically Necessary, separately identifiable service. Under these circumstances, the CHC may append modifier 25 to the evaluation and management visit service code (Subchapter 6, Section 604(C)).

CPT Code	Description
G0009	Administration of pneumoccal vaccine
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
96380	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services

- EPSDT visits may only be billed for eligible MassHealth members.
- The CHC may bill for a 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 (130 CMR 405.421 (F)). An EPSDT visit will be denied if billed on the same date of service as an Individual Medical Visit.
- Vaccine administration is separately payable with EPSDT visit.
- In addition to an EPSDT service, the Plan will reimburse the add-on code S0302 when all components of an EPSDT have been performed. CHCss must use the EPSDT codes 99381-99385 or 99391-99395 when billing an EPSDT visit in conjunction with add-on code S0302 to ensure correct payment.

CPT Code	**Description**

99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year) (Use for EPSDT visit)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years) (Use for EPSDT visit)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years) (Use for EPSDT visit)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years) (Use for EPSDT visit)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years (Use for EPSDT visit)
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year) (Use for EPSDT visit)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years) (Use for EPSDT visit)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years) (Use for EPSDT visit)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years) (Use for EPSDT visit)

99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years (Use for EPSDT visit)

EPSDT parent and caregiver depression, developmental, or autism spectrum disorder screening

- Screening the child's parent(s) or caregiver(s) for postpartum depression should now occur at every preventive pediatric visit from the one month visit to the twelve month visit.
- Pediatricians and pediatric providers must use CPT 96110 and modifiers U1, U2, U3, U4 and UG, as applicable, for Parent and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening.
- Note: Parent and Caregiver Depression Screening is billed using the child's member ID.
- If multiple screenings are performed during a single visit, it is permitted to list 96110 along with the appropriate modifier multiple times on the claim so long as different screenings are performed for each listing of 96110 and the exact modifiers do not repeat.
- Claims for CPT 96110 submitted for MassHealth ACO members 21 years of age and older will deny.
- Claims for CPT 96110 submitted without a U modifier will deny.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified.
U3 - No follow-up needed
U4 - Follow-up needed
UD - Administration and scoring of a standardized screening tool for parent and caregiver postpartum depression (used in combination with U1 or U2)

Code	Description
96110	Developmental screening, with scoring and documentation, per standardized instrument Parent and Caregiver Depression Screening should occur at every preventive pediatric visit from the one month visit to the twelve month visit, may be billed up to the twelve month preventive pediatric visit for the administration and scoring of a recommended postpartum depression screening tool, and must be billed with the UD modifier used together with either modifier - U1 or U2.
96110	Developmental screening, with scoring and documentation, per standardized instrument Developmental Screening, should occur at the 9-, 18-, and 30-month preventive pediatric visits and at any visit in which developmental surveillance elicits a concern, may be billed up to the age 8 preventative pediatric visit for administration and scoring of an age-appropriate standardized developmental screening tool per Appendix W and must be billed with modifier -U1 or -U2.
96110	Developmental screening, with scoring and documentation, per standardized instrument Autism Spectrum Disorder Screening, should occur at the 18- and 24-month preventive pediatric visits, may be billed up to the age 3 preventative

	pediatric visit for administration and scoring of a standardized autism screening tool per Appendix W and must be billed with modifier -U3 or -U4.

EPSDT behavioral health assessment and depression screening
Providers must use CPT 96127 and modifier U1 or U2, as applicable for Behavioral Health Assessment and Depression Screening.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified**.**

Code	Description
96127	Brief emotional/behavioral assessments, with scoring and documentation, per standardized instrument For members 4 to 21 years of age. From 4 to 11 years of age, to be billed for the administration of a standardized behavioral health screening tool per Appendix W. From 12 to 21 years of age, to be billed for the administration of a standardized depression screening tool per Appendix W. Must be billed with either modifier -U1 or -U2. Code 96127 is not payable when code 90791 is billed for the same date of service for the same member. For such dates of service, the provider must bill only code 90791).

EPSDT audiometric hearing and vision tests
Audiometric hearing (92551, 92552) and vision (92552, 92587) tests aare separately reimbursed with an EPSDT visit (Subchapter 6, Section 610).

Code	Description
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92587	Distortion product evoked otoacoustic emissions, limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
99173	Distortion product evoked otoacoustic emissions, comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

Perinatal depression screening
Claims for perinatal depression screening must be submitted with S3005 accompanied by one of the modifiers below to indicate whether a behavioral health need was identified.
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.
UD Perinatal Care Provider – Depression Screen: completed prenatal or postpartum.

CPT Code	Description
S3005	Performance measurement, evaluation of patient self-assessment, depression

Fluoride varnish services
- Covered for EPSDT-eligible MassHealth members .
- The CHC may bill for a medical visit in addition to the fluoride varnish application only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit (130 CMR 405.473 (C)).

- Effective August 19, 2025, when billing for fluoride varnish treatment provided during a well-child visit, CHCs must bill the CPT code 99188 and ICD-10 code Z00.129, Routine Child Health Check (Appendix Z, page Z-1).
- Effective August 19, 2025, when billing for fluoride varnish treatment provided during any other visit, providers must bill CPT code 99188 and ICD-10 code Z41.8, Need for Prophylactic Fluoride Administration (Appendix Z, page Z-1)

CPT Code	Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional

Administration of patient-focused or caregiver-focused health risk assessment instruments

CHCs may bill administration of patient-focused or caregiver-focused health risk assessment instruments with an individual medical visit with proper documentation. CPT 96160 and 96161 do not represent physician work. For payment purposes, each health risk assessment code is valued based on practice expense and professional liability only, which includes the cost of furnishing instruments (when applicable) and staff time to administer and/or score an instrument for the physician or other qualified health care professional's review. The physician's interpretation of the score in light of the patient/caregiver presentation is considered an evaluation and management service, which would be billed in addition to the health risk assessment code.

CPT Code	Description
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

Vaccine counseling services

CHCs may bill for either an individual medical visit or vaccine counseling services, but may not bill for both in a single visit (*Source: MassHealth All Provider Bulletin 362 March 2023*).

Code	Description
G0310	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5-15 mins time.
G0311	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time.
G0312	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5-15 mins time. (This code is used for Medicaid billing purposes.)
G0313	Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time.
G0314	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time.
G0315	Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 mins time.

Obstetric services - fee-for-service deliveries The Plan deny will obstetric service when billed with an individual medical visit (130 CMR 405.421 (F)).	
CPT Code	**Description**
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59414	Delivery of placenta (separate procedure)
59514	Cesarean delivery only;
59515	Cesarean delivery only; including postpartum care
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Obstetric services - global deliveries The Plan will deny obstetric service when billed with an individual medical visit (130 CMR 405.421 (F)).	
CPT Code	**Description**
59400	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59510	Vaginal delivery only (with or without episiotomy and/or forceps);
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Nurse midwife services The Plan will deny nurse midwife services when billed with an individual medical visit (130 CMR 405.421 (F)). Reminder: Effective November 1, 2025, all individual medical visits billed by CHCs using CPT code T1015 for services performed by a certified nurse midwife or obstetrician gynecologist (physician MDs/DOs only) must be accompanied by the TH modifier. The TH modifier must be used for all such visits, regardless of whether the service performed was related to prenatal or postpartum care.	
CPT Code	**Description**
T1015 TH	Use for all individual medical visits with a certified nurse midwife or obstetrician gynecologist
59400	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59414	Delivery of placenta (separate procedure)

59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

Hysterectomy services
The Plan will deny hysterectomy services when billed with an individual medical visit.

CPT Code	**Description**
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)

Contraceptives
- Drugs and biologicals dispensed in the CHC are payable, subject to the exclusions and service limitations at 130 CMR 405.417, 405.418, and 130 CMR 406.413(B): Drug Exclusions and (C): Service Limitations.
- Payment for drugs may be claimed in addition to an office visit.

CPT Code	**Description**
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use (includes applicator and cream or jelly)
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each (per package/tube)
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies
S4993	Contraceptive pills for birth control

Tobacco-cessation counseling services
The CHC may bill for a 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. This limitation does not apply to tobacco cessation counseling services provided by a physician or other qualified staff member under the supervision of a physician on the same day as a visit (130 CMR 405.421 (F)).

CPT Code	**Description**
99407	At least 30 minutes; eligible providers are physicians employed by community health centers
99407 HN	At least 30 minutes; eligible providers are physician assistants employed by community health centers
99407 HQ	For an individual in a group setting, 60-90 minutes; eligible providers are physicians employed by community health centers

99407 SA	At least 30 minutes; eligible providers are nurse practitioners employed by community health centers
99407 SB	At least 30 minutes; eligible providers are nurse midwives employed by community health centers
99407 TD	At least 30 minutes; eligible providers are registered nurses employed by community health centers
99407 TF	Intake assessment for an individual, at least 45 minutes; eligible providers are physicians employed by community health centers
99407 U1	At least 30 minutes; eligible providers are tobacco cessation counselors employed by community health centers
99407 U2	Intake assessment for an individual, at least 45 minutes; eligible providers are nurse practitioner, nurse midwife, physician assistant, registered nurse, and tobacco cessation counselor
99407 U3	For an individual in a group setting, 60-90 minutes; eligible providers are nurse practitioners, nurse midwives, physician assistants, registered nurses, and tobacco cessation counselors

Urgent care
Urgent care may be billed in addition to the individual medical visit (T1015).

CPT Code	Description
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service (Use for urgent care Monday through Friday from 5:00 p.m. to 6:59 a.m., and Saturday 7:00 a.m. to Monday 6:59 a.m.)

hiv pre- and post-test counseling visits

CPT Code	Description
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes (Use for HIV counseling visits)

Acupuncture services
Acupuncture service codes include the usual preservice and post-service work associated with acupuncture services (AMA CPT 2025 Professional Edition, page 881).

For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the CHC may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and an acupuncture service for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same CHC on the same day of the acupuncture service (130 CMR 415.474 (F)(2)).

CPT Code	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)

Medical nutrition therapy For MassHealth members receiving services under any of the Medical Nutrition Therapy (MNT) or Diabetes Self-Management Training (DSMT) codes on the same date of service as an office visit, CHCs may bill both office visit and MNT/DSMT codes.	
CPT Code	**Description**
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours, needed for renal disease), individual, face-to-face with patient, each 15 minutes
G0271	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours, needed for renal disease), group (2 or more individuals), each 30 minutes.

Diabetes self-management training For MassHealth members receiving services under any of the Medical Nutrition Therapy (MNT) or Diabetes Self-Management Training (DSMT) codes on the same date of service as an office visit, CHCs may bill both office visit and MNT/DSMT codes.	
CPT Code	**Description**
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management training services, individual, per 30 minutes

Audiology services A CHC must not bill an office visit when a member is seen for audiology services only (130 CMR 405.463 (B)).	
CPT Code	**Description**
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audfiometry (threshold); air and bone
92567	Tympanometry (impedence testing)

Electrocardiogram (EKG) services A CHC must not bill an office visit when a member is being seen for an EKG only (130 CMR 405.453(B)).	
CPT Code	**Description**
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
93040	Rhythm ECG, 1-3 leads; with interpretation and report

93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report
93042	Rhythm ECG, 1-3 leads; interpretation and report only

Cardiology services (diagnostic) X rays, laboratory tests, and certain diagnostic tests may be billed in addition to an office visit (130 CMR 405.421 (F)).	
CPT	Description
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only
93024	Ergonovine provocation test
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional
93225	External electrocardiographic recording up to 48 hours by continuous Ambulatory Cardiac Monitoring Page 9 of 14 Clinical Coverage Criteria Effective 07/01/2024 rhythm recording and storage; recording (includes connection, recording, and disconnection)
93226	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report
93227	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptomrelated memory loop with remote download capability up to 30 days, 24- hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional
93278	Signal-averaged electrocardiograpy (SAECG), with or without ECG
93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent

	superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)
93585	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemiazygos venous system (List separately in addition to code for primary procedure)
93586	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)
93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; enovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)
93588	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; enovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)
93724	Electronic analysis of antitachycardia pacemaker system (includes electrocardiographic recording, programming of device, induction and termination of tachycardia via implanted pacemaker, and interpretation of recordings)
93799	Unlisted cardiovascular service or procedure

Remote patient monitoring

- CPT 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to the patient and/or caregiver), and associated documentation.
- Do not report CPT 99091 in any calendar month in which CPT 99457, 99458 are reported.
- CPT 99091 may not be reported on the same day as an office visit. If the services described by 99091 are provided on the same day the patient presents for an office visit, these services should be considered part of the office visit and not reported separately.
- CPT 99453 Iinitial set-up and patient education) is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as “beginning when the remote monitoring service is initiated, and ends with attainment of targeted treatment goals (CPT® 2025 Professional Codebook, p. 44).”
- In order for a CHC to report CPT code 99454, the member must get the RPM device from the CHC, not through the durable medical equipment supplier or pharmacy. CHCs can only bill for the device once it has been given to an eligible member. All RPM devices must automatically transmits biomonitoring data to the provider without the member needing to manually report the data. All devices must be FDA-approved as a medical device.
- CPT 99454 is not to be reported more than once during a 30-day period.
- Review of CPT prefatory language (CPT® 2025 Professional Codebook, p. 44) provides additional information about the two physician-expense only codes. The CPT prefatory language indicates that monitoring must occur over at least 16 days of a 30-day period in order for CPT code 99454 to be billed. The Medically Necessary services associated with all the medical devices for a single patient can be billed by only one provider, only once per patient per 30-day period, and only when at least 16 days of data have been collected.
- CPT 99453 and 99454 may be reported on the same day as an office visit.
- Codes 99457, 99458 require interactive communication with the patient/caregiver. CPT 99457 may not be reported for services of less than 20 minutes, interactive communication contributes to the total time but does not need to make up the total time. Do not count any time on a day when the physician or other qualified health care professional reports an

office visit (CPT® 2025 Professional Codebook, p. 45-46). CPT 99457, 99458 may not be reported on the same day as an office visit.	
CPT Code	**Description**
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes

Medication therapy management (MTM) or Collaborative drug therapy management (CDTM) • The rendering provider on claims for MTM or CDTM must be a pharmacist. • MTM or CDTM can be billed alone or with other payable CHC services.	
CPT Code	**Description**
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient (use for CDTM or MTM services, limit of 2 units per calendar year)
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient (use for CDTM or MTM services, limit of 2 units per calendar year)
99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service) (use for CDTM or MTM services, limit of 3 units per visit and 12 units per calendar year)

Behavioral health integration (BHI) • The rendering provider on claims for BHI must be the member's primary care provider. • Services billed as BHI cannot also be billed as CoCM. • BHI can be billed alone or with other payable CHC services.	
CPT Code	**Description**
G0511	Behavioral health integration (BHI) services

Collaborative care management (CoCM) • The rendering provider on claims for CoCM must be the member's primary care provider. • Services billed as CoCM cannot also be billed as BHI.

• CoCM can be billed alone or with other payable CHC services.	
CPT Code	**Description**
G0512	Collaborative care management (CoCM) services

Coordinating Aligned, Relationship-centered, Enhanced Support for Kids program (CARES program) • May only be reported by certified CARES program providers for services rendered in accordance with the CARES program requirements to eligible MassHealth members. • All CARES program services must be rendered in accordance with regulations at 130 CMR 407.477 and MassHealth All Provider Bulletin 370 June 2023.	
CPT Code	**Description**
T2023	Targeted case management, per month

Place of service

This policy applies to services provided by Community Health Centers.

Policy history

Origination date:	09/01/2025
Connection date & details:	July 2025 – Policy origination. January 2026 – Under Reimbursement, added new section for Breast Cancer Screening pursuant to Chapter 231 of the Acts or 2024, updated Fluoride Varnish Services for MassHealth ACO members in accordance with MassHealth Transmittal Letter ALL-252, added new section for Perinatal Depression Screening in accordance with MassHealth All Provider Bulletin 405, added new section for Definitive Drug Testing Billed on the Same Date of Service as Presumptive Drug Testing, added new section for Annual Behavioral Health Wellness Examinations, added new Section Update to T1015 – TH Modifier Use.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.