Mass General Brigham
Health Plan

Mass General Brigham Health Plan Primary Care Sub-Capitation Resource Guide

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Definitions

Excluded Codes: Codes that are not included in the primary care sub-capitation and will therefore be paid per MassHealth fee schedules.

Excluded Specialty: Provider specialty types that are not included in the Primary Care Sub-Capitation

Included Codes: the service codes that are included in calculating the Primary Care Sub-Capitation Payment, as further specified by EOHHS. These codes will be paid $0 on claims.

Included Specialty: Providers that are included in the Primary Care Sub-Capitation.

Practice PID/SL: – A practice site in MassHealth's Medicaid Management Information System (MMIS). This Practice PID/SL is 10 characters, made up of a 9-digit base number and an alpha service location (e.g., 123456789A)

Primary Care Entity: An entity that may be made up of one or more unique Practice PID/SLs. For the purposes of Primary Care Sub-Capitation Program, the Primary Care Entity is the entity represented by the Tax ID for the Contract Year.

Primary Care Sub-Capitation Tier Requirements

1. **Annual Tier Attestation**

   Primary Care Practices are required to re-attest to the Tier annually on the timeline determined by EOHHS. During this annual re-attestation Practices may change the Tier in which they will participate.

   MGB Population Health Management will coordinate the annual attestation process with Practices.

2. **Complying with Tier**

   Primary Care Practices are required to meet all requirements of the Tier to which the Practice has attested per Appendix K for the contract year and as indicated in the provider contract with Mass General Brigham Health Plan.

   MGB Population Health Management along with Mass General Brigham Health Plan will support Practices in meeting requirements that are allowed to be provided centrally per MassHealth Appendix K.

3. **Practice Audits**

   Mass General Brigham Health Plan along with MGB Population Health Management will audit Practices to ensure compliance with Tier requirements for the tier to which a Practice has attested.

   This section will be updated as more information about MassHealth audit requirements and processes are determined.

Capitation Payment Frequently Asked Questions

1. **Entity receiving monthly capitation payments.**

   Mass General Brigham Health Plan will pay monthly capitation to the TINs participating in the Primary Care Sub-Capitation program. TINS will be paid via check or ACH.

2. **Timing of Monthly Capitation Payments**

   Capitation payments will be made to TINS monthly within seven days of Mass General Brigham Health Plan receiving payment from MassHealth. Capitation payment is expected to happen in the 3rd week of the month.

3. **Calculation of Monthly Capitation Payment**

   Monthly payments are calculated for each PCE/TIN based on the number of members in each rating category as of the first day of the month. Member months per rating category will then be calculated and multiplied by MassHealth PCP sub-capitation rate for each category. The sum of this calculation per PIDSL will be remitted to the TIN.

   If a member is only eligible for a portion of the month the capitation payment will be pro-rated corresponding to the portion of the month the member was eligible.

   The PMPM capitation rates will be inclusive of the sub-capitation and tiering dollars.

4. **Reconciliation of Monthly Capitation Payments**

   If MassHealth makes retro-active changes to eligibility or if there are retroactive changes to sub-cap provider assignment, Mass General Health Plan will reconcile the PMPM payments each month going back up to 6 months from the capitation month.

5. **Capitation Explanation of Payments (EOP)**

   Mass General Brigham Health Plan will send a monthly, member-level payment reporting with actual monthly payment. Capitation EOP – File Specification as provided below.

   a. Data File can be provided in excel or CSV file format with “” as qualifiers.

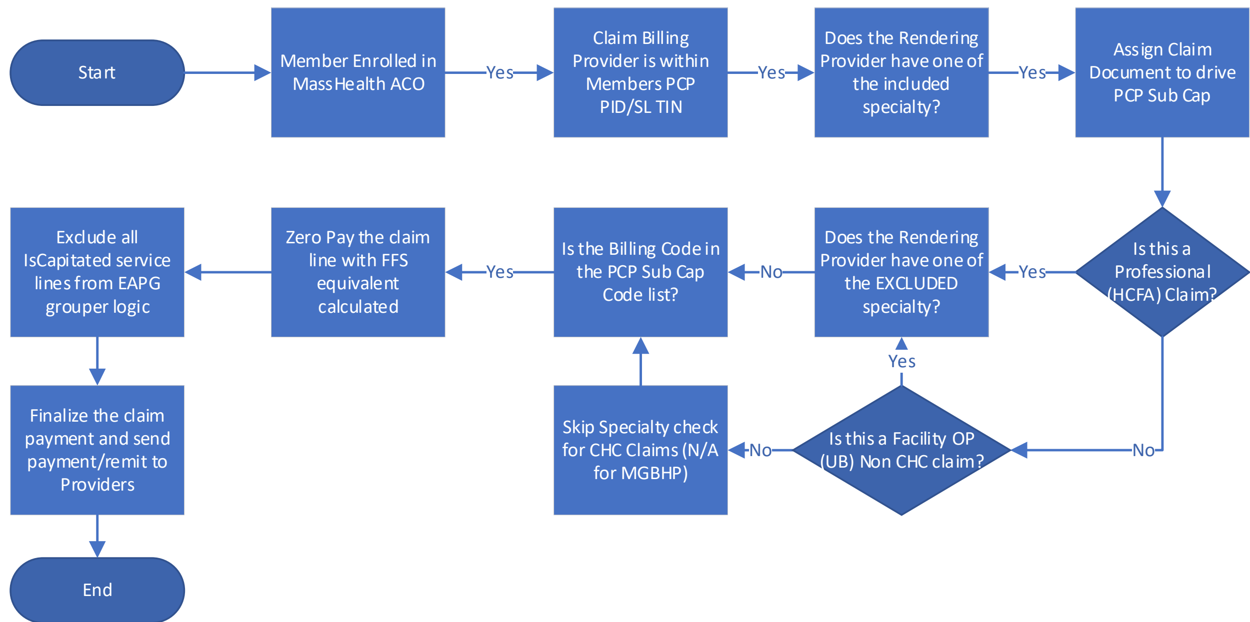
b. Data File can only be sent via secured SFTP transfer process.

c. File Name will have Provider/Vendor Name and Date of file generation. <PROVIDER>_YYYYMMDD_HHMMSS.txt

No	Data Fields	Description	Data Type
1	CapID	Internal capitation identifier which identifies a provider/vendor's capitation table.	Char(15)
2	Provider	Provider/Vendor's Name	Char(60)
3	Program	Line of business/program identifier	Char(15)
4	PCP Name	Member's Assigned PCP Full Name	Char(60)
5	Insurance Id	Member's Health Plan ID	Char(15)
6	Member Name	Member's Full Name	Char(60)
7	DOB	Member's Date of Birth	Char(10)
8	Sex	Member's Gender	Char(1)
9	Cap Month	Capitation Month	Number
10	Cap Year	Capitation Year	Number
11	Product	Member's Benefit Plan	Char(60)
12	Cap Rate	Capitation Rate (PMPM Rate)	Decimal(7,2)
13	Daycount	Number of covered days for the month	Number
14	Current Month Cap	Calculated PMPM Cap for covered days	Decimal(7,2)
15	Adjustment for Prior month	Calculated PMPM Cap for covered days if it is for previous months	Decimal(7,2)
16	OrgPolicy Description	Group Details	Char(60)
17	Network	PCP Network Description	Char(60)
18	Site	PCP Site (Affiliated Group) Identifier	Char(15)
19	Site Name	PCP Site (Affiliated Group) Name	Char(60)
20	PCP Provider Id	PCP (Provider) Identifier	Char(15)
21	GL Account	Internal account for tracking purpose	Char(60)
22	PCP NPI	PCP (Provider) NPI	Char(10)
23	Site NPI	PCP Site Affiliated Group) NPI	Char(10)
24	RateCode	MassHealth Rate Code (Not applicable for commercial plans)	Char(60)
25	CapTermDesc	Capitation Rate Table description	Char(60)
26	TypeOfCap	Capitation Type (Monthly)	Char(15)

Claims Adjudication Logic

Mass General Brigham Health Plan is implementing claims logic that aligns with guidance from MassHealth.



Claim Acceptance

- **Step 1:** Is the Member enrolled in a MGB ACO on the claim's first date of service? If yes, continue to Step 2.
- **Step 2:** Did the Member visit their assigned practice PID/SL or a practice PID/SL with the same Tax ID as their assigned PCP practice PID/SL? If yes, continue to Step 3.
- **Step 3:** Does the clinician[1] that rendered the service (rendering provider) have at least one specialty[2] on the "included" list? If yes, continue to Step 4.

Claim Adjudication

- **Step 4:** Determine whether the claim is a professional or facility claim.
    a. **Step 4a:** For professional claims (form type HCFA 1500), continue to Step 5.
    b. **Step 4b:** For facility claims (form type UB04), if the claim is an OP Hospital, continue to Step 5. These will be claims billed by the hospital with the service location address of one of their

[1] This clinician will be listed in the "billing provider" field for Individual Practitioner professional claims, the "rendering provider" field for GPO professional claims, and the "attending provider" field for OP Hospital/HLHC facility claims.
[2] These will be American Board of Medical Specialties (ABMS) specialties.

hospital affiliated clinics. MGBHP will ensure validation of attending providers for these claims.

  c. **Step 4c:** For HLHC claim (not applicable for MGBHP as there are no FQHC in network), continue to skip the specialty check and continue to Step 6.

- **Step 5:** Does the clinician (rendering or attending provider) have any specialties on the “excluded” list (see Appendix)? If no, continue to Step 6.
- **Step 6:** Is the procedure code on the primary care sub-capitation code list? If yes, continue to Step 7.
- **Step 7:** Zero-pay the claim line.
- **Step 8:** All zero-pay claim lines to be excluded from the EAPG custom pricing process.

Claims Payment:

Claims will be remitted to providers using Mass General Brigham Health Plan’s standard 837 format and Explanation of Payment (EOP). Capitated claim lines will be identified in 835s by following claim adjustment reason code (CARC).

24 - Charges are covered under a capitation agreement/managed care plan.

Mass General Brigham Health Plan
399 Revolution Drive, Suite 830
Somerville, MA 02145

Provider Mailing Address

Your name, ██████, and Tax ID have been verified by the IRS.

Mass General Brigham Health Plan
855-444-4647
Provider Service Center Hours:
8:00 AM to 6:00 PM EST (Monday - Friday)

Tax ID: ██████ ***EPC Draft #:*** ██████ ***Payment Week:*** *5* ***Payment Date:*** *02/09/2024* Page 1 of 28

Claim Number: ██████ **Patient Acct #:** **Check Number:** ██████
Billing Provider NPI: ██████ **Patient Name:** **Patient ID:** R
Provider:

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charges	Allowed Amount	Contractual Adjustment	COB	Withheld	Other Adjustment	Patient Obligation				Net Payment Amount
										Co-Ins	Co-Pay	Deductible	Non-Cov	
01/24/24	99213	1	45, 3	391.00	195.57	195.43	0.00	0.00	0.00	0.00	25.00	0.00	0.00	170.57
Claim Total:				391.00	195.57	195.43	0.00	0.00	0.00	0.00	25.00	0.00	0.00	170.57

Claim Number: ██████ **Patient Acct #:** **Check Number:** ██████
Billing Provider NPI: ██████ **Patient Name:** **Patient ID:** R
Provider:

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charges	Allowed Amount	Contractual Adjustment	COB	Withheld	Other Adjustment	Patient Obligation				Net Payment Amount
										Co-Ins	Co-Pay	Deductible	Non-Cov	
01/12/24	90756	1	45	66.00	32.37	33.63	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.37
01/12/24	90471	1	45	90.00	43.63	46.37	0.00	0.00	0.00	0.00	0.00	0.00	0.00	43.63
01/12/24	90472	1	45	64.00	32.62	31.38	0.00	0.00	0.00	0.00	0.00	0.00	0.00	32.62
01/12/24	99396 (25)	1	45	532.00	316.19	215.81	0.00	0.00	0.00	0.00	0.00	0.00	0.00	316.19
01/12/24	90715	1	45	85.00	38.31	46.69	0.00	0.00	0.00	0.00	0.00	0.00	0.00	38.31
Claim Total:				837.00	463.12	373.88	0.00	0.00	0.00	0.00	0.00	0.00	0.00	463.12

Claim Number: ██████ **Patient Acct #:** **Check Number:** ██████
Billing Provider NPI: ██████ **Patient Name:** **Patient ID:** R
Provider:

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charges	Allowed Amount	Contractual Adjustment	COB	Withheld	Other Adjustment	Patient Obligation				Net Payment Amount
										Co-Ins	Co-Pay	Deductible	Non-Cov	
01/22/24	96127	1	96	23.00	0.00	23.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
01/22/24	99396	1	45	532.00	242.68	289.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	242.68
Claim Total:				555.00	242.68	312.32	0.00	0.00	0.00	0.00	0.00	0.00	0.00	242.68

Included and Excluded Specialties

Included Specialty List of the provider rendering the services.

Specialty Description
ADOLESCENT MEDICINE
ADULT HEALTH NURSE PRACTITIONER
FAMILY NURSE PRACTITIONER
FAMILY PRACTICE
GENERAL PRACTICE
GERIATRIC MEDICINE
GERONTOLOGICAL NURSE PRACTITIONER
INTERNAL MEDICINE
OSTEOPATHIC MEDICINE
PEDIATRIC NURSE PRACTITIONER
PEDIATRICS
PHYSICIAN ASSISTANT
PREVENTIVE MEDICINE
PRIMARY NURSE CLINICIAN

Excluded Specialty List of the provider rendering the services.

Specialty Description
ADDICTION PSYCHIATRY
ANESTHESIOLOGY
CARDIAC SURGERY
COLON & RECTAL SURGERY
CERTIFIED NURSE ANESTHETIST
CLINICAL NEUROPHYSIOLOGY
CRITICAL CARE
DERMATOLOGY
DERMATOPATHY
FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY
GASTROENTEROLOGY
GYNECOLOGIC ONCOLOGY
HEMATOLOGY
MICROGRAPHIC DERMATOLOGIC SURGERY
NEPHROLOGY
NEURODEVELOPMENTAL DISABILITIES

NEUROLOGICAL SURGERY
NEUROLOGY
NEUROMUSCULAR MEDICINE
NEUROPATHOLOGY
NEURORADIOLOGY
NUCLEAR MEDICINE
NUCLEAR RADIOLOGY
ONCOLOGY
OPHTHALMOLOGY
ORTHOPEDIC SURGERY
OTOLARYNGOLOGY
PAIN MANAGEMENT
PATHOLOGY
PEDIATRIC CRITICAL CARE MEDICINE
PEDIATRIC DERMATOLOGY
PEDIATRIC GASTROENTEROLOGY
PEDIATRIC HEMATOLOGY
PEDIATRIC NEPHROLOGY
PEDIATRIC NEUROLOGY
PEDIATRIC ONCOLOGY
PEDIATRIC OPHTHALMOLOGY
PEDIATRIC OTOLARYNGOLOGY
PEDIATRIC PHYSICAL MEDICINE AND REHABILITATION
PEDIATRIC PULMONOLOGY
PEDIATRIC RADIOLOGY
PEDIATRIC RHEUMATOLOGY
PEDIATRIC SURGERY
PEDIATRIC UROLOGY
PHYSICAL MEDICINE AND REHABILITATION
PHYSICAL THERAPY
PLASTIC SURGERY
PLASTIC SURGERY-HEAD AND NECK
PSYCHIATRY
PULMONARY DISEASE
PULMONOLOGY

RADIATION THERAPY
RADIATION ONCOLOGY
RADIOLOGY - DIAGNOSTIC
RHEUMATOLOGY
SURGERY-GENERAL
SURGERY-HAND
SURGERY-ORAL & MAXILLOFACIAL
SURGERY-VASCULAR
THORACIC AND CARDIAC SURGERY
THORACIC SURGERY
UROLOGY
VASCULAR AND INTERVENTIONAL RADIOLOGY
VASCULAR NEUROLOGY

MassHealth Primary Sub-Capitation Included and Excluded Codes

Included Codes -

CPT Code	Definition
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)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument

96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous seven days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 15-29 minutes of total time is spent on the date or the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-44 minutes of total time spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 45-59 minutes of total time spent on the date of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 60-74 minutes of total time spent on the date of the encounter.
99211	Office or other outpatient visits for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 10-19 minutes of total time spent on the date of the encounter
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 20-29 minutes of total time spent on the date of the encounter.

99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-39 minutes of total time spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 40-54 minutes of total time spent on the date of the encounter.
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
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)
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)
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)
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)
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
99386	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; 40-64 years
99387	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; 65 years and older
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)
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)

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)
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)
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
99396	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; 40-64 years
99397	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; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
G0009	ADMINISTRATION OF PNEUMOCCOCCAL VACCINE
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month (Behavioral health integration; applies to all MassHealth community health centers)
G0512	Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month (applies to all MassHealth community health centers)
T1015	Clinic visit/encounter, all-inclusive

Excluded Codes

The following codes are **excluded** from the MassHealth ACO Primary Care Sub-Capitation Model. As such, practices will be paid fee-for-service for these codes. *(Note: The below list is not an exhaustive list of excluded codes. If a code does not appear on the included list the code will be excluded.)*

11981	90644	90743	99327	99489	H2016-HM
11982	90651	90746	99328	99490	H2020
11983	90653	90747	99334	99491	Q0091
57170	90654	90750	99335	99497	S0610

58300	90655	90756	99336	99498	S0612
58301	90656	90791	99337	99506	S0613
59400	90657	90792	99339	99605	S4981
59410	90658	90832	99340	99606	S9470
59425	90660	90833	99341	99607	S9484
59426	90661	90834	99342	0001A	
59430	90662	90836	99343	0002A	
59510	90668	90837	99344	0003A	
59515	90670	90838	99345	0011A	
59610	90672	90846	99347	0012A	
59614	90673	90847	99348	0013A	
59618	90674	90853	99349	0031A	
59622	90675	91300	99350	G0008	
90281	90676	91301	99355	G0010	
90283	90681	91303	99357	G0101	
90287	90682	96110	99359	G0102	
90291	90686	96127	99360	G0103	
90296	90688	96372	99374	G0123	
90371	90690	97802	99375	G0151	
90375	90691	97803	99376	G0179	
90376	90694	97804	99377	G0180	
90378	90696	99188	99378	G0181	
90389	90707	99234	99446	G0182	
90393	90710	99304	99447	G0402	
90396	90713	99305	99448	G0438	
90476	90714	99306	99449	G0439	
90477	90715	99307	99451	G0466	
90581	90716	99308	99452	G0467	
90585	90717	99309	99460	G0468	
90620	90732	99310	99461	G0476	
90621	90733	99315	99462	G0506	
90625	90734	99316	99463	G0511	
90630	90736	99318	99464	H0001	
90632	90738	99324	99465	H0032	
90633	90739	99325	99483	H0033	
90636	90740	99326	99487	H0046	

Effective Date: Jan. 1, 2023: Annual update to Included and Excluded Specialties as directed by MassHealth.

Revision Dates:

Jan. 1, 2024: Annual update to Included and Excluded Specialties as directed by MassHealth.

July 15, 2024: Update to remove Non-Payable Codes for included code set; minor change to Primary Care Entity definition to remove reference to 2023, added example EOP and alphabetized included and excluded specialties.

Jan. 1, 2025: Annual update to Excluded Specialties as directed by MassHealth.

May 1, 2025: Update to include new codes backdated to Jan. 1, 2025 as directed by MassHealth.