130 CMR 424.000: PODIATRIST SERVICES

Section

424.401: Introduction

All podiatrists participating in MassHealth must comply with the MassHealth regulations, including but not limited to regulations set forth in 130 CMR 424.000 and 450.000: *Administrative and Billing Regulations*.

424.402: Definitions

The following terms used in 130 CMR 424.000 have the meanings given in 130 CMR 424.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 424.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 424.000 and 450.000: *Administrative and Billing Regulations*.

Corrective Devices — orthotics, splints, inlays, appliances, and braces that support or accommodate part or all of the foot and serve to restore or improve functions of the foot.

Custom-molded Shoe — an individually patterned shoe fabricated to meet the specific needs of an individual. A custom-molded shoe is not off-the-shelf, stock, or prefabricated. The shoe is individually constructed by a molded process over a modified positive model of the individual's foot. It is made of leather or other suitable material of equal quality, has removable customized inserts that can be replaced if necessary according to the individual's condition, and has some form of shoe closure.

Drug — a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Emergency — a sudden or unexpected illness or injury or traumatic injury or infection other than athlete's foot or chronic mycosis infecting the nail bed that must be treated promptly to prevent severe pain to the member.

Flexible Adhesive Casting — the application of adhesive tape to orthopedically support or stabilize the foot, or to exert beneficial stress for a structural instability.

Hygienic Foot Care — the trimming of nonpathogenic nails; the cleansing or soaking of the feet; the use of skin creams to maintain skin tone of both ambulatory and bedridden patients; or such other foot care that can be performed by the member or by the nursing facility staff if the member resides in a nursing facility.

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Last — a model that approximates the shape and size of the foot and over which a shoe is made. A last is usually made of wood, plastic, or plaster.

Moldable Shoes — off-the shelf, ready-made shoes formed from heat-activated materials. The shoes are molded by a thermo-forming process that first heats the material, then forms it over an individual's foot or a positive model of the individual's foot.

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Nonstandard Size (Width or Length) — a shoe size made on a standard last pattern, but which is not part of a manufacturer's regular inventory.

Orthopedic Shoes — shoes that are specially constructed to aid in the correction of a deformity of the musculoskeletal structure of the foot and to preserve or restore the function of the musculoskeletal system of the foot.

424.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency covers podiatry services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

424.404: Provider Eligibility

Payment for services described in 130 CMR 424.000 is made only to providers who are participating in MassHealth on the date the service was provided or who are otherwise eligible for such payment pursuant to 130 CMR 450.000: *Administrative and Billing Regulations* and who meet the requirements of 130 CMR 424.404(A) and (B).

(A) In-state. A podiatrist practicing in Massachusetts must be licensed by the Massachusetts Board of Registration in Podiatry.

(B) Out-of-state. An out-of-state podiatrist must be licensed by that state's board of registration for podiatrists. The MassHealth agency pays an out-of-state podiatrist only when services are provided to an eligible Massachusetts member under the following circumstances:

(1) the podiatrist practices outside the Massachusetts border and provides emergency services to a member;

(2) the podiatrist practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that state; or

(3) the podiatrist provides services to a member who is authorized to reside out of state by the Massachusetts Department of Social Services.

424.405: Noncovered Services

The MassHealth agency does not pay for the following:

(1) hygienic foot care as a separate procedure, except when the member's medical record documents that the member cannot perform the care or risks harming himself or herself by

performing it. The preceding sentence notwithstanding, payment for hygienic foot care performed on a resident of a nursing facility is included in the nursing facility's *per diem* rate and is not reimbursable in any case as a separate procedure;

(2) canceled or missed appointments;

(3) services provided by a podiatrist whose contractual arrangements with a state institution, acute, chronic, or rehabilitation hospital, medical school, or other medical institution involve a salary, compensation in kind, teaching, research, or payment from any other sources, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care;

(4) telephone consultations;

(5) in-service education;

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(6) research or experimental treatment;
(7) cosmetic services or devices;
(8) sneakers or athletic shoes;
(9) an additional charge for nonstandard size (width or length) in custom-molded shoes; or
(10) shoes when there is no diagnosis of associated foot deformities.

424.406: Maximum Allowable Fees

The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for podiatry services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 424.000, 442.000, and 450.000. Payment for a service is the lowest of:

(A) the provider's usual and customary fee;

(B) the provider's actual charge; or

(C) the maximum allowable fee listed in the applicable DHCFP fee schedule.

424.407: Individual Consideration

(A) Some services listed in Subchapter 6 of the *Podiatrist Manual* are designated "I.C.," an abbreviation for individual consideration. Individual-consideration means that a fee could not be established. Payment for an individual-consideration service will be determined by the Division's professional advisors based on the podiatrist's descriptive report of the service furnished.

(B) To receive payment for an individual-consideration service, the podiatrist must submit with the claim a report that contains the diagnosis, a description of the condition of the foot, and the length of time spent with the member.

(C) Determination of the appropriate payment for an individual-consideration service is in accordance with the following criteria:
(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) the policies, procedures, and practices of other third-party insurers, both governmental and private;
(5) prevailing professional ethics and accepted customs of the podiatric community; and
(6) such other standards and criteria as may be adopted from time to time by DHCFP or the Division.

(D) For shoes and corrective devices *see* 130 CMR 442.421 and 442.422.

424.408: Referral

When, during an examination or as a result of laboratory tests, a podiatrist discovers a debilitating or systemic disease (such as diabetes mellitus or ischemia caused by circulatory deficiency), the podiatrist must inform the member that a physician evaluation is necessary and

must document this referral in the member's medical record.

424.409: Recordkeeping (Medical Records) Requirements

Payment for any service listed in 130 CMR 424.000 is conditioned upon its full and complete documentation in the member's medical record.

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(A) The medical record must contain sufficient data to fully document the nature, extent, and necessity of the care furnished to a member for each date of service claimed for payment, as well as any data that will update the member's medical course. The data maintained in the medical record must also be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals.

(B) Although basic data collected during previous visits (for example, identifying data, chief complaint, or history) do not need to be repeated in the member's medical record for subsequent visits, the medical records of each service provided by a podiatrist at any location must include, but not be limited to:

(1) the member's name and date of birth;
(2) the date of each service;
(3) the reason for the visit;
(4) the name and title of the person performing the service;
(5) the member's medical history;
(6) the diagnosis or chief complaint;
(7) a clear indication of all findings, whether positive or negative, on examination;
(8) any medications administered or prescribed, including strength, dosage, route, regimen, and duration of use;
(9) a description of any treatment given;
(10) recommendations for additional treatments or consultations, when applicable;
(11) any medical goods or supplies dispensed or prescribed;
(12) any tests administered and their results;
(13) documentation of a treatment plan if subsequent visits are expected;
(14) documentation, when applicable, that the member was informed of the necessity of a physician evaluation; and
(15) MassHealth Shoe Medical Necessity Form (if applicable).

424.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the podiatrist's claim for payment when the service is designated "I.C." in Subchapter 6 of the *Podiatrist Manual* or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable professional advisors to assess the extent and nature of the services.

(B) Operative Report. For surgery procedures designated "I.C." in Subchapter 6 of the *Podiatrist Manual*, operative notes must accompany the podiatrist's claim. An operative report must state the operation performed, the name of the member, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the podiatrist and his or her assistants, and the technical procedures performed.

424.411: Office Visits

The MassHealth agency pays for four types of office visits: initial, limited, extended, and follow-up. The fees vary depending on the type of visit.

(A) The MassHealth agency pays for one initial visit (the member's first visit to a podiatrist) per member. This visit must include an initial comprehensive history, results of laboratory tests or

other findings, whether positive or negative, and identification of both podiatric and general medical problems through vascular, orthopedic, neurological, dermatological, and musculoskeletal examination. The fee for an initial visit includes necessary treatment for relief of symptoms.

(B) The MassHealth agency pays for one limited visit per member within a 30-day period. A limited visit must include an interval history and examination and treatment of the foot, which may include removal of excrescences; palliative and prophylactic onychial care; treatment of hypertrophied toenails; and electroburring when the record documents that the member has a localized illness, injury, or symptoms involving the foot, including diabetes or peripheral vascular disease.

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(C) The MassHealth agency pays for one extended visit per member within a 30-day period. An extended visit must include the application of flexible adhesive casting, minor modification to shoes, or electric modality physiotherapy. An extended visit may also include the removal of excrescences, palliative and prophylactic onychial care, treatment of hypertrophied or ingrown nails (or both), and other comparable procedures.

(D) The MassHealth agency pays for one follow-up visit per member per week. A follow-up visit is a return visit for a specific diagnosis (such as warts or an ulcer) in which a brief procedure, such as a dressing change, debridement, or removal of sutures, is performed.

(E) Payment for the removal of an ulcerated keratosis is included in the fees for any type of visit and must not be billed for separately.

(F) The MassHealth agency pays for either an office visit or a treatment or surgical procedure for the same member on the same date of service but not both.

424.412: Out-of-office Visits

The MassHealth agency pays for podiatric care provided in a hospital, a member's home, or a long-term-care facility only when the following conditions are met.

(A) Podiatric care provided in any of the above settings is designed to treat a diagnosed condition, to minimize bed confinement, and to increase the member's activity.

(B) The podiatrist performs and documents a complete evaluation and all necessary treatment for relief of the member's symptoms or for the diagnosed condition.

(C) If further treatment is required, the podiatrist formulates a treatment plan and includes it in the member's medical record. This plan must justify any further diagnostic procedures, additional treatment, return visits, or referrals and must include the following information:

(1) a diagnosis of the member's podiatric condition;
(2) results of X rays and other diagnostic tests, if performed; and
(3) a description of treatment provided and recommendations for additional treatment.

(D) The treatment plan is updated after each visit and details the member's progress.

(E) Documentation of all out-of-office visits, including the member's evaluation, progress, and treatment plan, must be kept either in the podiatrist's office or at the appropriate facility where the service is provided.

(F) Payment is limited to one out-of-office visit per member in a 30-day period in a long-term-care facility or the member's home and two visits in a 30-day period for a member in a hospital setting.

(G) The MassHealth agency pays for either a visit or a treatment procedure. The MassHealth agency does not pay for both a visit and a treatment or surgical procedure provided to a member on the same day in the same location.

424.413: Surgery Services: Introduction

Surgical procedures must be performed in a podiatrist's office, in a hospital, or in a freestanding ambulatory surgical center.

(A) Provider Eligibility. The MassHealth agency pays a podiatrist for surgery only if the podiatrist is scrubbed and present in the operating room during the major portion of the operation.

(B) Nonpayable Services. The MassHealth agency does not pay for

(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment;

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(2) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of disease or physical defect, or traumatic injury;
(3) services billed under codes listed in Subchapter 6 of the *Podiatrist Manual* as not payable;
(4) services otherwise identified in MassHealth regulations at 130 CMR 424.000 or 450.000: *Administrative and Billing Regulations* as not payable; and
(5) services billed with otherwise-covered service codes when such codes are used to bill for nonpayable services as described in 130 CMR 424.405.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 424.413 and 424.414, unless otherwise indicated.
(1) Complications Following Surgery - all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.
(2) Evaluation and Management (E/M) Services - visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.
(3) Intraoperative Services - intraoperative services that are normally a usual and necessary part of a surgical procedure.
(4) Major Surgery - a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines that the preoperative period is one day and the postoperative period is 90 days.
(5) Minor Surgery - a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or ten days.
(6) Postoperative Period -
(a) The postoperative period for major surgery is 90 days.
(b) The postoperative period for minor surgery and endoscopies is zero or ten days.
(7) Postoperative Visits - follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.
(8) Postsurgical Pain Management - postsurgical pain management by the surgeon, including supplies.
(9) Preoperative Period -
(a) The preoperative period for major surgery is one day.
(b) The preoperative period for minor surgery is zero days.
(10) Preoperative Visits - preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

424.414: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Podiatrist Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 424.000 and 450.000.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency

pays a podiatrist for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy.

(B) Payment for Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services are included in the global surgical package regardless of setting, including but not limited to hospitals, ambulatory surgical centers, and podiatrists' offices.

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(1) The following services are included in the payment for a global surgery when furnished by the podiatrist who performs the surgery:

(a) preoperative visits;

(b) intraoperative visits;

(c) complications following surgery;

(d) postoperative visits;

(e) postsurgical pain management;

(f) miscellaneous services related to surgery, including but not limited to dressing changes; local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes; and changes and removal of tracheostomy tubes; and

(g) visits related to the surgery to a patient in an intensive care or critical care unit, if made by the podiatrist. Intensive or critical care visits unrelated to surgery are not included in the global surgical package.

(2) The following services are not included in the payment for a global surgery:

(a) the initial consultation or evaluation of the problem by the podiatrist to determine the need for surgery;

(b) services of other podiatrists except where the surgeon and the other podiatrist or podiatrists agree on the transfer of care during the global period. Such transfer agreement must be in writing and a copy of the written transfer agreement must be kept in the member's medical record;

(c) visits unrelated to the diagnosis for which the surgical procedure is performed;

(d) treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the surgery;

(e) diagnostic tests and procedures, including diagnostic radiological procedures;

(f) clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications resulting from the surgery. A new postoperative period begins with the subsequent surgical procedure. This exception includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure;

(g) treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical that there would be insufficient time for transportation to an OR); and

(h) a second, more extensive procedure required because the initial, less extensive procedure did not produce the desired outcome.

(C) Payment for Multiple Surgeries. Multiple surgeries are separate procedures performed by a podiatrist on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from intraoperative services and surgeries that are incidental to or components of a primary surgery (that is, bundled services). Bundled services are not paid separately. When two or more related procedures are performed on a patient during a single session or visit, the MassHealth agency pays the provider for the comprehensive code and denies or adjusts the component, incidental, or mutually exclusive procedure performed during the same session. The bundling guidelines that MassHealth applies are based upon generally accepted

industry guidelines including, but not limited to the Correct Coding Initiative administered through the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association's *Current Procedural Terminology (CPT)* code book. To receive payment for multiple surgeries, the surgeon must bill with the multiple surgery modifier.

(D) Payment for Multiple Endoscopy Procedures. When multiple procedures are performed through the same endoscope, payment is made for the highest valued endoscopy procedure plus the difference between the next highest valued endoscopy procedure and the base endoscopy procedure. The base endoscopy procedure is included in the code for each of the multiple procedures. When two related endoscopies and an unrelated endoscopy are performed, the endoscopic payment rule stated above applies to the related endoscopies. Unrelated endoscopic

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procedures are treated as separate surgeries and paid as multiple surgeries pursuant to 130 CMR 424.414(C).

(E) Payment for Add-on Surgical Procedures. The Centers for Medicare & Medicaid Services (CMS) has identified certain procedures as add-on procedures that are always billed with another procedure. Add-on codes are identified in the CPT code book. By definition, these services do not stand alone and must be provided in conjunction with a primary surgical procedure or qualifying service. Both the service code for the primary procedure and add-on code are paid separately. The global surgery package provisions at 130 CMR 424.413 and 424.414 apply to the service code for the primary procedure.

(F) Payment for Bilateral Procedures. Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day. To receive payment, the podiatrist must use the bilateral surgery modifier with the appropriate service code. The provider must not use the bilateral surgery modifier with service codes containing the terms "bilateral" or "unilateral or bilateral" in their definitions, since the terminology of the code identifies the service as one whose payment accounts for any additional work required for bilateral surgery.

(G) Surgical Assistants. Some surgical procedures require a primary surgeon and an assistant surgeon. A surgical assistant must meet the requirements for provider eligibility specified in 130 CMR 424.404. To receive payment, the assistant surgeon must use the appropriate modifier. Surgical codes that accept the surgical assistant modifiers are indicated in the *Correct Coding Initiative Guide*. In addition, the MassHealth agency does not pay for a surgical assistant if

(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 424.414(H) or a two-surgeon modifier pursuant to 130 CMR 424.414(I);

(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency pays for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery; or

(3) the surgical procedure does not require the services of more than one surgeon.

(H) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery." The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other members of the surgical team.

(I) Two Surgeons (Co-surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. Payment includes all surgical assistant fees.

424.415: Radiology Services

(A) The MassHealth agency pays for radiology services when the services are needed to confirm the diagnosis of a bony or calcific disorder, to detect soft-tissue disorders, or to detect

foreign bodies.

(B) Payment for radiology services is not included in the fees for visits and should be claimed separately.

(C) All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(D) The MassHealth agency pays a podiatrist for radiology services only when the service is provided in the podiatrist's office and only when the films are developed and read in the podiatrist's office.

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(E) All X rays must be labeled with the member's name, the date of examination, and the nature of the examination in addition to the information required in 130 CMR 424.409.

(F) The MassHealth agency pays one maximum allowable fee for a routine study of a particular section of an extremity regardless of the number of X-ray views. An additional fee may be claimed only when a comparison study is necessary.

424.416: Clinical Laboratory Services

(A) The MassHealth agency pays the podiatrist only for laboratory tests listed in the *Podiatrist Manual* and only when the tests are administered and analyzed in the podiatrist's office. The MassHealth agency pays a certified independent clinical laboratory or hospital-licensed clinical laboratory if the laboratory tests are performed at the clinical laboratory.

(B) The MassHealth agency pays for clinical laboratory tests that are necessary for the diagnosis or treatment of conditions of the foot only.

(C) Only the following laboratory tests may be administered without prior authorization:
(1) complete blood count or any of the separate components of such an analysis, including red cell count, white cell count, or hemoglobin;
(2) hematocrit;
(3) fungus culture;
(4) sensitivity, culture, and colony count;
(5) fasting blood sugar;
(6) platelet count;
(7) uric acid;
(8) complete urinalysis; and
(9) combination urinary dip stick (pH, blood, ketones, glucose, nitrites).

(D) The podiatrist must include the following information with any specimen submitted to a certified independent clinical laboratory or hospital-licensed clinical laboratory:
(1) a signed request for the laboratory services to be performed;
(2) the member's identification number, which appears on the member's MassHealth card; and
(3) the podiatrist's name, address, and provider number.

424.417: Pharmacy Services: Drugs Dispensed in Pharmacies

Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers and related prescription requirements for prescribing clinicians, are governed by 130 CMR 406.000: *Pharmacy Services*.

424.423: Drugs Administered in the Office (Physician-administered Drugs)

(A) Payment.
(1) Drugs and biologicals administered in the office are payable, subject to the exclusions and service limitations at 130 CMR 424.405, 424.407, and 130 CMR 406.413(B): *Drug Exclusions* and (C): *Service Limitations*.
(2) The MassHealth agency does not pay a podiatrist separately for drugs that are considered

routine and integral to the delivery of a podiatrist's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the podiatrist fee for the service.

(3) The MassHealth agency does not pay separately for any oral drugs administered in the office for which the podiatrist has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization.

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(4) Claims for drugs and biologicals that are listed in Subchapter 6 of the *Podiatrist Manual* must include the name of the drug or biological, strength, dosage, and number of HCPCS units dispensed, NDC code, NDC units and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Podiatrist Manual* a copy of the invoice showing the actual acquisition cost must be attached to the claim form, Claims without this information are denied.

(5) The MassHealth agency 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: *Medicine*.

(6) Payment for drugs may be claimed in addition to an office visit.

(B) Prior Authorization. Prior authorization requirements for drugs are included in the MassHealth Drug List and the Subchapter 6 of the *Podiatrist Manual*. All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Podiatrist Manual*.

424.424: Shoes and Corrective Devices

(A) The MassHealth agency pays for only those shoes listed in Subchapter 6 of the *Podiatrist Manual*.

(B) For shoes, providers must submit with their claim a copy of the applicable completed MassHealth Orthotic and Prosthetic Prescription and Medical Necessity Form.

(C) The MassHealth agency does not pay for casting materials used in the molding of orthotic shoes or corrective devices. The cost of these materials is included in the fee for prescribing and providing the shoe or corrective device.

424.425: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary podiatry services 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 424.000, and with prior authorization.

REGULATORY AUTHORITY

130 CMR 424.000: M.G.L. c. 118E, §§ 7 and 12.