Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER POD-45
October 2003

TO: Podiatrists Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Podiatrist Manual* (Revised Regulations and Service Codes and Descriptions)

Updated Podiatry Regulations

This letter transmits revised podiatry regulations. The regulation retains the life-and-safety certification requirement but no longer requires the certification to be attached to the podiatrist claim for payment with the exception of shoes and other corrective devices. However, the life-and-safety certification must be retained as documentation in the member's medical record. Additionally, regulatory changes were made to sections about shoes and corrective devices.

Revised Subchapter 6 (Service Codes)

This letter transmits a revised Subchapter 6 of the *Podiatrist Manual.* 2003 HCPCS (Healthcare Common Procedure Coding System) codes have been added to replace certain MassHealth local codes. The local codes have been replaced so that the Division's coding requirements are compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996).

Subchapter 6 of the *Podiatrist Manual* lists CPT and Level II codes that:

- are payable under MassHealth; and
- have special limitations or requirements, such as prior authorization or individual consideration.

Providers should use this revised Subchapter 6 in conjunction with the *American Medical Association Current Procedural Terminology (CPT) 2003* code book and the Ingenix HCPCS Level II 2003 code book, as the Division is no longer including the service descriptions of payable codes.

Please find attached a crosswalk from the obsolete MassHealth local service codes and modifiers to the new national service codes and modifiers for the revised Subchapter 6.

Effective Date

The revised regulations are effective for dates of service on or after October 16, 2003. The new codes introduced in Subchapter 6 under the CPT 2003 code book and the 2003 HCPCS Level II code book are effective for dates of service on or after October 16, 2003. We will accept either the new or old codes for dates of service through November 15, 2003. For dates of service on or after November 16, 2003, providers must use the new codes to receive payment.

How to Obtain a Podiatry Fee Schedule

If you wish to obtain a fee schedule, you may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts State Bookstore or from the Division of Health Care Finance and Policy. See addresses and telephone numbers below. You must contact them first to find out the price of the publication. The Division of Health Care Finance and Policy also has the regulations available on disk. The regulation title for Podiatric Care is 114.3 CMR 26.00: Podiatric Care. The regulation title for surgery and anesthesia is 114.3 CMR 16.00: Surgery and Related Anesthesia Care. The regulation title for radiology is 114.3 CMR 18.00: Radiology.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

Miscellaneous

The remainder of this transmittal letter contains information, clarifications, and instructions relating to MassHealth billing.

A. Referrals for Podiatric Care

Podiatry services require a written referral from the member's primary care provider prior to the delivery of services. The Division pays only for podiatry services that are certified to be necessary for the life and safety of the member. The referral must be on the primary-care provider's letterhead and must certify that such services are medically necessary for the life and safety of the member. A substantiating medical explanation must be included in the written certification. The life and safety referral must be retained in the member's medical record. See 130 CMR 424.405(A) and 424.409(B). **The life and safety referral no longer needs to be submitted with the claim.**

For shoes and other corrective devices, providers must submit with their claim a copy of the completed MassHealth Shoe Medical Necessity Form and a copy of the life and safety documentation from the primary care provider. See 130 CMR 424.405.

Periodically, the Division may ask podiatry providers to verify the issuance of the life and safety documentation. In cases where the Division reviews have revealed provider noncompliance with 130 CMR 450.205(A) through (C), the Division may seek to pursue recovery of overpayments and to impose sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

B. Routine Drugs Dispensed in a Podiatrist's Office (99070)

The Division does not pay separately for routine drugs dispensed in the office when they are integral to the podiatrist's professional services in the course of diagnosis and treatment. Such drugs are commonly provided by the podiatrist without charge, and payment is

included in the MassHealth payment for the professional service.

The Division considers certain drugs, including but not limited to those listed below, to be routine drugs:

- Demerol
- Vistaril.

C. Shoes and Corrective Devices

Shoes and corrective devices are paid on an individual consideration (I.C.) basis subject to the regulations set forth in the *Orthotics Manual* at 130 CMR 442.420, 442.421, and 442.422. An *Orthotics Manual* may be obtained by contacting MassHealth Provider Enrollment and Credentialing, P.O. Box 9101, Somerville, MA 02145. The *Orthotics Manual* regulations are also located on the Division's Web site at www.mass.gov/dma.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Podiatrist Manual

Pages 4-1 through 4-6, 4-13, 4-14, and 6-1 through 6-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Podiatrist Manual

Pages 4-1 through 4-4, 4-13, and 4-14 — transmitted by Transmittal Letter POD-43

Pages 4-5 and 4-6 — transmitted by Transmittal Letter POD-39

Pages 6-1 through 6-4 — transmitted by Transmittal Letter POD-42

Podiatrist
Service Code Crosswalk
Effective October 16, 2003

Obsolete Code	Obsolete Code Description	New Code	New Code Description
X1705	Examination and treatment of the feet in a licensed hospital, successive members, same day	99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; and • a medical decision making that is straightforward or of low complexity.
		99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • an expanded problem focused interval history; and • a expanded problem focused examination; • a medical decision making of moderate complexity.
X1707	Examination and treatment of the feet in the member's residence, successive members, same day	99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; and • straightforward medical decisionmaking.
		99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; and • medical decision making of low complexity.
		99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a detailed interval history; • a detailed examination; and • medical decision making of moderate complexity.
X1709	Examination and treatment of the feet in a licensed nursing facility, convalescent home, charitable home for the aged, or rest home, successive members, same day	99311	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; and • medical decision making that is straightforward or of low complexity.
		99312	Subsequent nursing facility care, per day for the evaluation and management of a new or established patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; and • medical decision making of moderate complexity.
		99331	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; and • medical decision making that is straightforward or of low complexity.
		99332	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; and • medical decision making of moderate complexity.

Podiatrist
Service Code Crosswalk
Effective October 16, 2003

Obsolete Code	Obsolete Code Description	New Code	New Code Description
X1711	Visit to member living more than 10 miles away from podiatrist's place of business, and no podiatrist is practicing in the community in which the member lives	99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; and • Straightforward medical decisionmaking.
		99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; and • medical decision making of low complexity.
		99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a detailed interval history; • a detailed examination; and • medical decision making of moderate complexity.
X1720	Other X-ray (I.C.)	76499	Unlisted diagnostic radiographic procedure (I.C.)
X3333	Injectable and infusible drugs and devices supplied in a physician's office that require prior authorization (I.C.) (P.A.)	J3490	Unclassified drugs (Prior authorization required.) (I.C.) (P.A.)

Modifier	Description	Comments
W8	Emergency treatment in a nursing facility	Modifier deleted, no longer in use

424.401: Introduction

All podiatrists participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 424.000 and 450.000.

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 in 130 CMR 450.000.

Controlled Substance – a drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

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.

Interchangeable Drug Product – a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A"-rated) by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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.

Legend Drug – any drug for which a prescription is required by applicable federal or state law or regulation.

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the Division. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 424.419(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 424.000.

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.

Multiple-Source Drug – a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug – any drug for which no prescription is required by federal or state law.

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.

Pharmacy On-Line Processing System (POPS) – the on-line, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Split-Size Charge – an additional charge for dispensing an off-the-shelf, medical-grade pair of orthopedic shoes, where one shoe in the pair is a different size or width than the other shoe in the pair.

Unit-Dose Distribution System – a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

424.403: Eligible Members

(A) (1) MassHealth Members. The Division covers podiatry services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 424.00 and 450.000, the Division covers shoes only when provided to eligible MassHealth members under age 21. This age restriction does not apply to therapeutic, moldable, or custom-molded shoes and shoe inserts for members who have severe diabetic foot disease.

(3) 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.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

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 and who meet the following requirements.

(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 Division 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 border of Massachusetts 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: Service Limitations and Noncovered Services

(A) Services Limited to Life and Safety. The Division pays only for podiatry services that are certified to be necessary for the life and safety of the member. The Division pays for podiatry services as long as the podiatrist has a written certification on letterhead from the member's primary care physician that attests that such services are medically necessary for the life and safety of the member and that contains a substantiating medical explanation.

(B) Noncovered Services. The Division 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;

(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 the following:

(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 is 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.

(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) need not 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, the following:

(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;
(15) Life and Safety Certification (see 130 CMR 424.405); and
(16) 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.

(2) The Division does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of chargethrough local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs;

(c) drugs used for the treatment of male or female sexual dysfunction;
drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The Division, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993; and
retinoids for members aged 26 or older. The Division pays for retinoids for members under age 26, and all other topical acne products for members of all ages who have cases of acne Grade II or higher, without prior authorization.

(3) The Division does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The Division does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the Division determines to be consistent with current medical evidence.

424.420: Pharmacy Services: Insurance Coverage

(A) Managed Care Organizations. The Division does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(B) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the Division for the primary insurer's copayment for the primary carrier's preferred drug without regard to whether the Division generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 424.419(C)(2)(a), (c), (d), and (e). In such cases, the prescriber must obtain prior authorization from the Division in order for the pharmacy to bill the Division for the primary insurer's copayment.

424.421: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the Division for drugs identified by the Division in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 424.418(A)(1) and 424.419(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the Division for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Podiatrist Manual*. If the Division approves the request, the Division will notify both the podiatrist and the member.

(C) The Division authorizes at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See 42 U.S.C. 1396r-8(d)(5).) The Division acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

(E) The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 424.417 through 424.421. The Division will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List.

424.422: Pharmacy Services: Member Copayments

The Division requires under certain conditions that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in the Division's administrative and billing regulations at 130 CMR 450.130.

424.423: Drugs Dispensed in Provider's Office

Drugs dispensed in the office are payable at the podiatrist's actual acquisition cost if this cost is more than $1.00. Claims for dispensing drugs must include the name of the drug or biological, the strength, and the dosage. A copy of the invoice showing the actual acquisition cost must be attached to the claim form, and must include the National Drug Code (NDC). Claims without this information will be denied.

424.424: Shoes and Corrective Devices

(A) The Division 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 completed MassHealth Shoe Medical Necessity Form and a copy of the Life and Safety Certification from the primary care physician. (See 130 CMR 424.405.)

(C) The Division 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.

REGULATORY AUTHORITY

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

601 Introduction

The Division pays for the services for codes listed in Sections 602 through 604 in effect at the time of service, subject to all conditions and limitations in the Division's regulations at 130 CMR 424.000 and 450.000.

Podiatry services require a written referral from the member's primary-care provider before the delivery of services. The Division pays only for podiatry services that are certified to be necessary for the life and safety of the member. The referral must be on the primary-care provider's letterhead and must certify that such services are medically necessary for the life and safety of the member. A substantiating medical explanation must also be included in the written certification.

- Section 602 lists CPT service codes that are payable under MassHealth, some of which require individual consideration or prior authorization. MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology* (CPT) *2003* code book for the service codes and descriptions when billing for CPT codes provided to MassHealth members.

- Sections 603 and 604 list Level II HCPCS codes that are payable under MassHealth. MassHealth providers must refer to Ingenix's *HCPCS Level II 2003* code book for the descriptions of the codes when billing for Level II HCPCS codes provided to MassHealth members.

- Section 605 lists service code modifiers allowed under MassHealth.

Legend:

I.C.: Claim requires individual consideration. See 130 CMR 424.407 for more information.
P.A.: Service requires prior authorization. See 130 CMR 450.303 for more information.

602 Payable CPT Codes

The Division pays for services billed using the following codes.

10060	11001	11057 (I.C.)	11308	11621
10061	11040	11100	11420	11622
10120	11041	11101	11421	11623
10121	11042	11200	11422	11624
10140	11043	11201	11423	11626
10160	11044	11305	11424	11719
10180	11055	11306	11426	11720
11000	11056	11307	11620	11721

602 Payable CPT Codes (cont.)

11730	17000	27685	28092	28262
11732	17003	27686	28100	28264
11740	17004	27695	28102	28270
11750	17110	27696	28103	28272
11752	17111	27704	28104	28280
11755	17250	27760	28106	28285
11760	17270	27762	28107	28286
11762	17271	27766	28108	28288
11765	17272	27808	28110	28289
12001	17273	27810	28111	28290
12002	17274	27814	28112	28292
12004	17276	27816	28113	28293
12005	20000	27818	28114	28294
12006	20005	27822	28116	28296
12007	20200	27823	28118	28297
12041	20205	27840	28119	28298
12042	20206	27842	28120	28299
12044	20520	27846	28122	28300
12045	20525	27848	28124	28302
13131	20550	27860	28126	28304
13132	20600	27870	28130	28305
13133	20605	28001	28140	28306
14040	20612	28002	28150	28307
14041	20615	28003	28153	28308
14060	20650	28005	28160	28309
14061	20670	28008	28171	28310
14300	20680	28010	28173	28312
14350	27603	28011	28175	28313
15000	27604	28020	28190	28315
15001	27605	28022	28192	28320
15050	27606	28024	28193	28322
15100	27607	28030	28200	28340
15101	27610	28035	28202	28341
15120	27612	28043	28208	28344
15121	27613	28045	28210	28345
15240	27614	28046	28220	28360 (I.C.)
15241	27615	28050	28222	28400
15350	27618	28052	28225	28405
15351	27619	28054	28226	28406
15400	27620	28060	28230	28415
15401	27625	28062	28232	28420
15574	27626	28070	28234	28430
15620	27630	28072	28238	28435
15850	27647	28080	28240	28436
15851	27648	28086	28250	28445
15852	27680	28088	28260	28450
15999 (I.C.)	27681	28090	28261	28455

602 Payable CPT Codes (cont.)

28456	28630	29425	73650	99231
28465	28635	29440	73660	99232
28470	28636	29445	76499 (I.C.)	99238
28475	28645	29450	81000	99239
28476	28660	29515	82947	99241
28485	28665	29540	84550	99242
28490	28666	29550	85007	99243
28495	28675	29580	85014	99251
28496	28705	29590	85018	99252
28505	28715	29705	85032	99253
28510	28725	29730	85041	99261
28515	28730	29750	85048	99262
28525	28735	29799 (I.C.)	87101	99281
28530	28737	29891	87102	99282
28531	28740	29892	87106	99283
28540	28750	29893	99070 (I.C.)	99311
28545	28755	29894	99202	99312
28546	28760	29895	99203	99321
28555	28800	29897	99204	99322
28570	28805	29898	99211	99331
28575	28810	29899	99212	99332
28576	28820	73590	99213	99341
28585	28825	73592	99214	99342
28600	28899 (I.C.)	73600	99218	99343
28605	29345	73610	99219	99347
28606	29355	73620	99221	99348
28615	29405	73630	99222	99349

603 Payable HCPCS Level II Service Codes for Injectable and Infusable Drugs Administered in the Office

The Division pays for the services for codes listed in Section 603 in effect at the time of service, subject to all conditions and limitations in Subchapter 6 and in the Division's regulations at 130 CMR 424.000 and 450.000. All services for codes listed in this section are paid on an individual consideration (I.C.) basis. See 130 CMR 424.407 for more information.

J0170 (I.C.)	J0702 (I.C.)	J0704 (I.C.)	J1020 (I.C.)	J1030 (I.C.)
J1040 (I.C.)	J1200 (I.C.)	J1700 (I.C.)	J1710 (I.C.)	J2000 (I.C.)
J3301 (I.C.)	J3302 (I.C.)	J3303 (I.C.)	J3490 (I.C.) (P.A.)	S0020 (I.C.)

604 Payable HCPCS Level II Service Codes for Diabetic Shoes and Orthotic Services

The Division pays for the services for codes listed in Section 604 in effect at the time of service, subject to all conditions and limitations in Subchapter 6 and in the Division's regulations at 130 CMR 424.000 and 450.000. In addition, each code lists the age restriction and service limitations that apply. All service codes listed in this section are paid on an individual consideration (I.C.) basis. See 130 CMR 424.407 for more information.

HCPCS Code	Covered Under Age 21	Covered Ages 21 and Older	Service Limitations
A5500 (I.C.)	Yes	Yes	4 per 12 months
A5501 (I.C.)	Yes	Yes	4 per 12 months
A5503 (I.C.)	Yes	Yes	4 per 12 months
A5504 (I.C.)	Yes	Yes	4 per 12 months
A5505 (I.C.)	Yes	Yes	4 per 12 months
A5506 (I.C.)	Yes	Yes	4 per 12 months
A5507 (I.C.)	Yes	Yes	4 per 12 months
A5508 (I.C.)	Yes	Yes	4 per 12 months
A5509 (I.C.)	Yes	Yes	12 per 12 months
A5511 (I.C.)	Yes	Yes	4 per 12 months
L3000 (I.C.)	Yes	No	4 per 12 months
L3001 (I.C.)	Yes	No	4 per 12 months
L3002 (I.C.)	Yes	No	4 per 12 months
L3003 (I.C.)	Yes	No	4 per 12 months
L3010 (I.C.)	Yes	No	4 per 12 months
L3020 (I.C.)	Yes	No	4 per 12 months
L3030 (I.C.)	Yes	No	4 per 12 months
L3040 (I.C.)	Yes	No	4 per 12 months
L3050 (I.C.)	Yes	No	4 per 12 months
L3060 (I.C.)	Yes	No	4 per 12 months
L3070 (I.C.)	Yes	No	4 per 12 months
L3080 (I.C.)	Yes	No	4 per 12 months
L3090 (I.C.)	Yes	No	4 per 12 months
L3100 (I.C.)	Yes	No	2 per 12 months
L3140 (I.C.)	Yes	No	2 per 12 months
L3150 (I.C.)	Yes	No	2 per 12 months
L3160 (I.C.)	Yes	No	2 per 12 months
L3170 (I.C.)	Yes	No	2 per 12 months
L3201 (I.C.)	Yes	No	4 per 12 months
L3202 (I.C.)	Yes	No	4 per 12 months
L3203 (I.C.)	Yes	No	4 per 12 months
L3204 (I.C.)	Yes	No	4 per 12 months
L3206 (I.C.)	Yes	No	4 per 12 months
L3207 (I.C.)	Yes	No	4 per 12 months

604 Payable HCPCS Level II Service Codes for Diabetic Shoes and Orthotic Services (cont.)

HCPCS Code	Covered Under Age 21	Covered Ages 21 and Older	Service Limitations
L3208 (I.C.)	Yes	No	4 per 12 months
L3209 (I.C.)	Yes	No	4 per 12 months
L3211 (I.C.)	Yes	No	4 per 12 months
L3212 (I.C.)	Yes	No	2 per 12 months
L3213 (I.C.)	Yes	No	2 per 12 months
L3214 (I.C.)	Yes	No	2 per 12 months
L3215 (I.C.)	Yes	No	2 per 12 months
L3216 (I.C.)	Yes	No	2 per 12 months
L3217 (I.C.)	Yes	No	2 per 12 months
L3219 (I.C.)	Yes	No	2 per 12 months
L3221 (I.C.)	Yes	No	2 per 12 months
L3222 (I.C.)	Yes	No	2 per 12 months
L3224 (I.C.)	Yes	No	4 per 12 months
L3225 (I.C.)	Yes	No	4 per 12 months
L3230 (I.C.)	Yes	No	4 per 12 months
L3250 (I.C.)	Yes	No	4 per 12 months
L3251 (I.C.)	Yes	No	4 per 12 months
L3252 (I.C.)	Yes	No	4 per 12 months
L3253 (I.C.)	Yes	No	4 per 12 months
L3254 (I.C.)	Yes	No	2 per 12 months
L3255 (I.C.)	Yes	No	2 per 12 months
L3257 (I.C.)	Yes	No	2 per 12 months
L3260 (I.C.)	Yes	No	4 per 12 months
L3265 (I.C.)	Yes	No	4 per 12 months
L3300 (I.C.)	Yes	No	4 per 12 months
L3310 (I.C.)	Yes	No	4 per 12 months
L3320 (I.C.)	Yes	No	4 per 12 months
L3332 (I.C.)	Yes	No	2 per 12 months
L3334 (I.C.)	Yes	No	4 per 12 months
L3350 (I.C.)	Yes	No	4 per 12 months
L3360 (I.C.)	Yes	No	4 per 12 months
L3370 (I.C.)	Yes	No	4 per 12 months
L3390 (I.C.)	Yes	No	4 per 12 months
L3400 (I.C.)	Yes	No	4 per 12 months
L3420 (I.C.)	Yes	No	4 per 12 months
L3450 (I.C.)	Yes	No	4 per 12 months
L3455 (I.C.)	Yes	No	4 per 12 months
L3460 (I.C.)	Yes	No	4 per 12 months
L3465 (I.C.)	Yes	No	4 per 12 months
L3470 (I.C.)	Yes	No	4 per 12 months

604 Payable HCPCS Level II Service Codes for Diabetic Shoes and Orthotic Services (cont.)

HCPCS Code	Covered Under Age 21	Covered Ages 21 and Older	Service Limitations
L3480 (I.C.)	Yes	No	4 per 12 months
L3485 (I.C.)	Yes	No	4 per 12 months
L3500 (I.C.)	Yes	No	4 per 12 months
L3510 (I.C.)	Yes	No	4 per 12 months
L3530 (I.C.)	Yes	No	4 per 12 months
L3540 (I.C.)	Yes	No	4 per 12 months
L3570 (I.C.)	Yes	No	4 per 12 months
L3580 (I.C.)	Yes	No	4 per 12 months
L3590 (I.C.)	Yes	No	4 per 12 months
L3595 (I.C.)	Yes	No	4 per 12 months
L4210 (I.C.)	Yes	Yes	--

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth. See Subchapter 5 of the *Podiatrist Manual* for billing instructions related to the use of modifiers.

26	Professional component
50	Bilateral procedure
51	Multiple procedures
99	Multiple modifiers
TC	Technical component