Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter POD-60
October 2008

TO: Podiatrists Participating in MassHealth

FROM: Tom Dehner, Medicaid Director

RE: *Podiatrist Manual* (Elimination of Life and Safety Requirement)

With Podiatrist Bulletin 16 (June 2008), MassHealth eliminated the limitation on podiatry services to those necessary for the life and safety of the member, and the corresponding requirement that providers obtain and provide a life and safety certification with claims for payment for podiatry services. This letter transmits an amendment to the podiatrist regulations that codifies these changes. However, MassHealth covers only podiatry services that are medically necessary and, in addition, all other provisions of 130 CMR 424.000 and 450.000 continue to apply. For members who belong to the PCC Plan, podiatry services will continue to require a referral from the member's primary-care (PCC) clinician before the delivery of services.

This letter also transmits a revised Subchapter 6 of the *Podiatrist Manual*. Subchapter 6 lists the codes that are covered by MassHealth. For dates of service on or after January 1, 2008, Service Code J7345 has been discontinued by CMS and replaced with Service Code J7347.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

This transmittal letter and other publications issued by MassHealth are available on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

NEW MATERIAL

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

Podiatrist Manual

Pages iv, 4-3 through 4-6, 4-15, 4-16, and 6-1 through 6-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Podiatrist Manual

Pages iv, 4-3, 4-4, 4-15, and 4-16 — transmitted by Transmittal Letter POD-59

Pages 4-5 and 4-6 — transmitted by Transmittal Letter POD-45

Pages 6-1 through 6-6 — transmitted by Transmittal Letter POD-57

4. Program Regulations

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 MassHealth agency pays for podiatry services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 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.

(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 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 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 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: 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;

(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 MassHealth agency'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; 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.

424.421: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 424.418 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 MassHealth agency 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 MassHealth agency approves the request, it will notify both the podiatrist and the member.

(C) The MassHealth agency will authorize 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 MassHealth agency 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 MassHealth agency 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 MassHealth agency 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 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 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 completed MassHealth Shoe 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 et seq., 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.

601 Introduction

MassHealth providers must refer to the American Medical Association's Current Procedural Terminology (CPT) code book for the service codes and service descriptions when billing for services provided to MassHealth members. MassHealth pays for the services represented by the codes listed in Sections 602 through 604 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 424.000 and 450.000. In addition, a podiatrist may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act in accordance with 130 CMR 450.144, 42 U.S.C.1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member younger than 21 years of age, even if it is not designated as covered or payable in Subchapter 6 of the *Podiatrist Manual*.

For members who belong to the PCC Plan, podiatry services continue to require a referral from the member's primary-care (PCC) clinician before the delivery of services.

Section 602 lists CPT service codes that are generally payable under MassHealth, some of which require individual consideration (IC) or prior authorization (PA).

Sections 603 and 604 list Level II HCPCS codes that are payable under MassHealth.

Section 605 lists service code modifiers allowed under MassHealth.

Legend:

IC: Claim requires individual consideration. See 130 CMR 424.407 for more information.
PA: Service requires prior authorization. See 130 CMR 450.303 for more information.

602 Payable CPT Codes

10060	11305	11740	14041	15136
10061	11306	11750	14060	15150
10120	11307	11752	14061	15151
10121	11308	11755	14300	15152
10140	11420	11760	14350	15155
10160	11421	11762	15002	15156
10180	11422	11765	15003	15157
11000	11423	12001	15004	15170
11001	11424	12002	15005	15171
11040	11426	12004	15050	15175
11041	11620	12005	15100	15176
11042	11621	12006	15101	15240
11043	11622	12007	15110	15241
11044	11623	12041	15111	15300
11055	11624	12042	15115	15301
11056	11626	12044	15116	15320
11057	11719	12045	15120	
11100	11720	13131	15121	
11101	11721	13132	15130	
11200	11730	13133	15131	
11201	11732	14040	15135	

602 Payable CPT Codes (cont.)

15321	20650	28005	28160	28309
15330	20670	28008	28171	28310
15331	20680	28010	28173	28312
15335	27603	28011	28175	28313
15336	27604	28020	28190	28315
15340	27605	28022	28192	28320
15341	27606	28024	28193	28322
15360	27607	28035	28200	28340
15361	27610	28043	28202	28341
15365	27612	28045	28208	28344
15366	27613	28046	28210	28345
15400	27614	28050	28220	28360
15401	27615	28052	28222	28400
15420	27618	28054	28225	28405
15421	27619	28055	28226	28406
15430	27620	28060	28230	28415
15431 (IC)	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 (IC)	27681	28090	28261	28455
17000	27685	28092	28262	28456
17003	27686	28100	28264	28465
17004	27695	28102	28270	28470
17110	27696	28103	28272	28475
17111	27704	28104	28280	28476
17250	27760	28106	28285	28485
17270	27762	28107	28286	28490
17271	27766	28108	28288	28495
17272	27808	28110	28289	28496
17273	27810	28111	28290	28505
17274	27814	28112	28292	28510
17276	27816	28113	28293	28515
20000	27818	28114	28294	28525
20005	27822	28116	28296	28530
20200	27823	28118	28297	28531
20205	27840	28119	28298	28540
20206	27842	28120	28299	28545
20520	27846	28122	28300	28546
20525	27848	28124	28302	28555
20550	27860	28126	28304	28570
20600	27870	28130	28305	28575
20605	28001	28140	28306	28576
20612	28002	28150	28307	28585
20615	28003	28153	28308	28600

602 Payable CPT Codes (cont.)

28605	28810	29893	85048	99251
28606	28820	29894	87101	99252
28615	28825	29895	87102	99253
28630	28890 (PA)	29897	87106	99281
28635	28899 (IC)	29898	99070 (IC)	99282
28636	29345	29899	99202	99283
28645	29355	73590	99203	99307
28660	29405	73592	99204	99308
28665	29425	73600	99211	99309
28666	29440	73610	99212	99324
28675	29445	73620	99213	99325
28705	29450	73630	99214	99326
28715	29515	73650	99218	99334
28725	29540	73660	99219	99335
28730	29550	76499 (IC)	99221	99336
28735	29580	81000	99222	99341
28737	29590	82947	99231	99342
28740	29705	84550	99232	99343
28750	29730	85007	99238	99347
28755	29750	85014	99239	99348
28760	29799 (IC)	85018	99241	99349
28800	29891	85032	99242	
28805	29892	85041	99243	

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

MassHealth pays for the services represented by the codes listed in Section 603 in effect at the time of service, subject to all conditions and limitations in Subchapter 6 and in MassHealth regulations at 130 CMR 424.000 and 450.000. Refer to the Centers for Medicare & Medicaid Services Web site at www.cms.gov/medicare/hcpcs for detailed descriptions when billing with Level II HCPCS codes for services provided to MassHealth members.

J0702	J1040	J3302	J7341	J7346
J0704	J1710 IC)	J3303	J7342	J7347
J1020	J1720	J3490 IC)	J7343	S0020
J1030	J3301	J7340	J7344	

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

MassHealth pays for the services represented by the codes listed in Section 604 in effect at the time of service, subject to all conditions and limitations in MassHealth regulations at 130 CMR 442.000 and 450.000. In addition, a provider may request PA for any medically necessary orthotic services.

Providers should refer to the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool for service descriptions, applicable modifiers, place-of-service codes, PA requirements, service limits, American Orthotic and Prosthetic Association (AOPA) interpretive language (if applicable), pricing and markup information, and MassHealth Shoe Prescription Form requirement. For certain services that are payable on an individual-consideration (I.C.) basis, the tool will calculate the payable amount, based on information entered into certain fields on the tool. For service codes for which the Division of Health Care Finance and Policy (DHCFP) has established a rate, the provider can determine the payment by reviewing the DHCFP regulations at 114.3 CMR 34.00.

The MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool also contains links to DHCFP regulations, the MassHealth Shoe Prescription Form, Subchapter 4 of the orthotics regulations, Subchapter 4 of the prosthetics regulations, and Part 6 of the administrative and billing instructions, which lists the error codes and explanations for claims that have been denied or suspended by MassHealth. Providers should note that in the upper left corner of the Payment and Coverage Guidelines tool, above the words Program Link, there is a date. Providers should make sure if they download a printed copy that the dates are the same. This will ensure that the providers use the current tool.

To get to the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool, go to www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then Provider Library, and then MassHealth Payment and Coverage Guidelines Tools.

If you want a paper copy of the tool, you can print it from the Web site, or request a copy from MassHealth Customer Service. See Appendix A of your provider manual for applicable contact information.

A5500	L3010	L3170	L3216	L3257	L3400	L3520
A5501	L3020	L3201	L3217	L3260	L3410	L3530
A5503	L3030	L3202	L3219	L3265	L3420	L3540
A5504	L3031	L3203	L3221	L3300	L3430	L3550
A5505	L3040	L3204	L3222	L3310	L3440	L3560
A5506	L3050	L3206	L3224	L3320	L3450	L3570
A5507	L3060	L3207	L3225	L3330	L3455	L3580
A5508	L3070	L3208	L3230	L3332	L3460	L3590
A5512	L3080	L3209	L3250	L3334	L3465	L3595
A5513	L3090	L3211	L3251	L3350	L3470	
L3000	L3100	L3212	L3252	L3360	L3480	
L3001	L3140	L3213	L3253	L3370	L3485	
L3002	L3150	L3214	L3254	L3380	L3500	
L3003	L3160	L3215	L3255	L3390	L3510	

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
LT Left side (for orthotic shoes only)
RT Right side (for orthotic shoes only)
TC Technical component

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