Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter POD-72
May 2015

TO: Podiatrists Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary and Director of MassHealth DT

RE: *Podiatrist Manual* (2015 HCPCS)

This letter transmits revisions to the service codes in the *Podiatrist Manual*. The Centers for Medicare & Medicaid Services (CMS) has revised the Healthcare Common Procedure Coding System (HCPCS) for 2015. The revised Subchapter 6 is effective for dates of service on or after January 1, 2015.

Providers should refer to www.cms.hhs.gov for service descriptions.

Subchapter 6 of the *Podiatrist Manual* lists CPT and Level II codes that are payable by MassHealth for this provider type and also any special limitations or requirements that are applicable to those codes, such as prior authorization (PA) or individual consideration (IC).

A podiatrist may request prior authorization for any medically necessary service reimbursable under the federal Medicaid Act, in accordance with 130 CMR 450.144 and 42 U.S.C. 1396d(a) and 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*.

If you wish to obtain a fee schedule, you may download the Executive Office of Health and Human Services regulations at no cost at www.mass.gov/eohhs. The specific regulation titles are 101 CMR 317.00: Medicine; 114.3 CMR 18.00: Radiology, 101 CMR 320.00: Clinical Laboratory Services, and 101 CMR 334.00: Prostheses, Prosthetic Devices, and Orthotic Devices, and 114.3 CMR 16.00: Surgery and Anesthesia Services.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

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

NEW MATERIAL

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

Podiatrist Manual

Pages vi and 6-1 through 6-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Podiatrist Manual

Page vi — transmitted by Transmitted Letter POD-67

Pages 6-1 through 6-6 — transmitted by Transmittal Letter POD-69

6. Service Codes and Descriptions

601 Introduction

This Subchapter 6 includes Level I (numeric) and Level II (alpha) HCPCS codes. When billing for services provided to MassHealth members, MassHealth providers must refer to the American Medical Association's *Current Procedural Terminology (CPT)* 2015 codebook for the service descriptions of Level I HCPCS codes and to the Centers for Medicare & Medicaid Services website at www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html for the descriptions of Level II HCPCS codes. 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 (PA) for any medically necessary service reimbursable under the federal Medicaid Act, in accordance with 130 CMR 450.144 and 42 U.S.C. 1396d(a) and 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 Primary Care Clinician (PCC) Plan, podiatry services continue to require a referral from the member's PCC before the delivery of services.

- Section 602 lists CPT codes for services 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 for services that are payable under MassHealth.
- Section 605 lists service code modifiers allowed for billing under MassHealth.

Legend

IC: Claim requires individual consideration. See 130 CMR 424.407 and 450.271 for more information.
PA: Service requires prior authorization. See 130 CMR 450.303 for more information.

602 Payable CPT Codes

10060	11200	11721	13131	15116
10061	11201	11730	13132	15120
10120	11305	11732	13133	15121
10121	11306	11740	14040	15130
10140	11307	11750	14041	15131
10160	11308	11752	14060	15135
10180	11420	11755	14061	15136
11000	11421	11760	14301	15150
11001	11422	11762	14302	15151
11042	11423	11765	14350	15152
11043	11424	12001	15002	15155
11044	11426	12002	15003	15156
11045	11620	12004	15004	15157
11046	11621	12005	15005	15240
11047	11622	12006	15050	15241
11055	11623	12007	15100	15271
11056	11624	12041	15101	15272
11057	11626	12042	15110	15273
11100	11719	12044	15111	15274
11101	11720	12045	15115	15275

602 Payable CPT Codes (cont.)

15276	27615	28050	28210	28344
15277	27618	28052	28220	28345
15278	27619	28054	28222	28360
15574	27620	28055	28225	28400
15620	27625	28060	28226	28405
15850	27626	28062	28230	28406
15851	27630	28070	28232	28415
15852	27647	28072	28234	28420
15999 (IC)	27648	28080	28238	28430
17000	27680	28086	28240	28435
17003	27681	28088	28250	28436
17004	27685	28090	28260	28445
17110	27686	28092	28261	28450
17111	27695	28100	28262	28455
17250	27696	28102	28264	28456
17270	27704	28103	28270	28465
17271	27760	28104	28272	28470
17272	27762	28106	28280	28475
17273	27766	28107	28285	28476
17274	27808	28108	28286	28485
17276	27810	28110	28288	28490
20005	27814	28111	28289	28495
20200	27816	28112	28290	28496
20205	27818	28113	28292	28505
20206	27822	28114	28293	28510
20520	27823	28116	28294	28515
20525	27840	28118	28296	28525
20550	27842	28119	28297	28530
20600	27846	28120	28298	28531
20604	27848	28122	28299	28540
20605	27860	28124	28300	28545
20606	27870	28126	28302	28546
20612	28001	28130	28304	28555
20615	28002	28140	28305	28570
20650	28003	28150	28306	28575
20670	28005	28153	28307	28576
20680	28008	28160	28308	28585
27603	28010	28171	28309	28600
27604	28011	28173	28310	28605
27605	28020	28175	28312	28606
27606	28022	28190	28313	28615
27607	28024	28192	28315	28630
27610	28035	28193	28320	28635
27612	28043	28200	28322	28636
27613	28045	28202	28340	28645
27614	28046	28208	28341	28660

602 Payable CPT Codes (cont.)

28665	29355	29898	87102	99238
28666	29405	29899	87106	99239
28675	29425	73590	97597	99281
28705	29440	73592	97598	99282
28715	29445	73600	97602	99283
28725	29450	73610	97605	99307
28730	29515	73620	97606	99308
28735	29540	73630	99070 (IC)	99309
28737	29550	73650	99202	99324
28740	29580	73660	99203	99325
28750	29582	76499 (IC)	99204	99326
28755	29705	81000	99211	99334
28760	29730	82947	99212	99335
28800	29750	84550	99213	99336
28805	29799 (IC)	85007	99214	99341
28810	29891	85014	99218	99342
28820	29892	85018	99219	99343
28825	29893	85032	99221	99347
28890 (PA)	29894	85041	99222	99348
28899 (IC)	29895	85048	99231	99349
29345	29897	87101	99232	

603 **P**ayable 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.

J0702	J1710 (IC)	J3303	Q4103	Q4108
J1020	J1720	J3490 (IC)	Q4104	Q4110
J1030	J3301	Q4101	Q4106	S0020
J1040	J3302	Q4102	Q4107	

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 424.000 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 Executive Office of Health and Human Services (EOHHS) has established a rate, the provider can determine the payment by reviewing the EOHHS regulations at 101 CMR 334.00.

The MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool also contains links to EOHHS regulations, the MassHealth Shoe Prescription Form, the orthotics regulations, the prosthetics regulations, and 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, there is a date above the words Program Link. Providers should make sure that the dates are the same if they download a printed copy. 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 Guideline Tools.

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

A5500	L3030	L3206	L3250	L3360	L3510
A5501	L3031	L3207	L3251	L3370	L3520
A5503	L3040	L3208	L3252	L3380	L3530
A5504	L3050	L3209	L3253	L3390	L3540
A5505	L3060	L3211	L3254	L3400	L3550
A5506	L3070	L3212	L3255	L3410	L3560
A5507	L3080	L3213	L3257	L3420	L3570
A5508	L3090	L3214	L3260	L3430	L3580
A5510	L3100	L3215	L3265	L3440	L3590
A5512	L3140	L3216	L3300	L3450	L3595
A5513	L3150	L3217	L3310	L3455	
L3000	L3160	L3219	L3320	L3460	
L3001	L3170	L3221	L3330	L3465	
L3002	L3201	L3222	L3332	L3470	
L3003	L3202	L3224	L3334	L3480	
L3010	L3203	L3225	L3340	L3485	
L3020	L3204	L3230	L3350	L3500	

605 Modifiers

The following service code modifiers are allowed for billing under MassHealth.

24 Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service
26 Professional component
50 Bilateral procedure
51 Multiple procedures
57 Decision for surgery
58 Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
59 Distinct procedural service
78 Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79 Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
91 Repeat clinical diagnostic laboratory test
99 Multiple modifiers
LT Left side (used to identify procedures performed on the left side of the body)
RT Right side (used to identify procedures performed on the right side of the body)
T1 Left foot, second digit
T2 Left foot, third digit
T3 Left foot, fourth digit
T4 Left foot, fifth digit
T5 Right foot, great toe
T6 Right foot, second digit
T7 Right foot, third digit
T8 Right foot, fourth digit
T9 Right foot, fifth digit
TA Left foot, great toe
TC Technical component
XE Separate encounter: a service that is distinct because it occurred during a separate encounter
XP Separate practitioner: a service that is distinct because it was performed by a different practitioner
XS Separate structure: a service that is distinct because it was performed on a separate organ/structure
XU Unusual nonoverlapping service: the use of a service that is distinct because it does not overlap usual components of the main service

605 Modifiers (cont.)

The following modifiers are for Provider Preventable Conditions (PPCs) that are National Coverage Determinations.

PA Surgical or other invasive procedure on wrong body part
PB Surgical or other invasive procedure on wrong patient
PC Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see Appendix V of your provider manual.

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