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

MassHealth

Transmittal Letter POD-76

April 2022

 **TO:** Podiatrists Participating in MassHealth

 **FROM:** Amanda Cassel Kraft, Assistant Secretary for MassHealth [Signature of Amanda Cassel Kraft]

**RE:***Podiatrist Manual* (2022 HCPCS Updates to Subchapter 6 Codes)

This letter transmits revisions to the service codes in Subchapter 6 of the *Podiatrist Manual*. The Centers for Medicare & Medicaid Services (CMS) has revised the Healthcare Common Procedure Coding System (HCPCS) codes for 2022. The revised Subchapter 6 is effective for dates of service on or after January 1, 2022. Providers should refer to www.cms.hhs.gov for service descriptions.

Subchapter 6 of the *Podiatrist Manual* lists CPT and Level II HCPCS 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 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*.

If you wish to obtain a fee schedule, you may download the Executive Office of Health and Human Services regulations at no cost at <http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html>. The specific regulation titles are 101 CMR 317.00: *Rates for Medicine Services;* 101 CMR 318.00: *Radiology Services*; 101 CMR 320.00: *Clinical Laboratory Services*; 101 CMR 334.00: *Prostheses, Prosthetic Devices, and Orthotic Devices*; and 101 CMR 316.00: *Rates for Surgery and Anesthesia Services*.

**MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth](http://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, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

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NEW MATERIAL

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

Podiatrist Manual

Pages 6-1 through 6-6

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Podiatrist Manual

Page 6-1 through 6-6 — transmitted by Transmittal Letter POD-75

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 Professional Procedural Terminology (CPT)* 2017 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](http://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

10061

10120

10121

10140

10160

10180

11000

11001

11042

11043

11044

11045

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11047

11055

11056

11057

11100

11101

11200

11201

11305

11306

11307

11308

11420

11421

11422

11423

11424

11426

11620

11621

11622

11623

11624

11626

11719

11720

11721

11730

11732

11740

11750

11752

11755

11760

11762

11765

12001

12002

12004

12005

12006

12007

12041

12042

12044

12045

13131

13132

13133

14040

14041

14060

14061

14301

14302

14350

15002

15003

15004

15005

15050

15100

15101

15110

15111

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15116

15120

15121

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15131

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15240

15241

15271

15272

15273

15274

15275

15276

15277

15278

15574

15620

15850

15851

15852

15999 (IC)

17000

17003

17004

17110

17111

17250

17270

17271

17272

17273

17274

17276

20005

20200

20205

20206

20520

20525

20550

20600

20604

20605

20606

20612

20615

20650

20670

20680

27603

27604

27605

27606

27607

27610

27612

27613

27614

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27618

27619

27620

27625

27626

27630

27647

27648

27680

27681

27685

27686

27687

27691

27695

27696

27702

27704

27760

27762

27766

27808

27810

27814

27816

27818

27822

27823

27840

27842

27846

27848

27860

27870

28001

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28705

28715

28725

28730

28735

28737

28740

28750

28755

28760

28800

28805

28810

28820

28825

28890 (PA)

28899 (IC)

29345

29355

29405

29425

29440

29445

29450

29515

29540

29550

29580

29582

29705

29730

29750

29799 (IC)

29891

29892

29893

29894

29895

29897

29898

29899

73590

73592

73600

73610

73620

73630

73650

73660

76499 (IC)

81000

82947

84550

85007

85014

85018

85032

85041

85048

87101

87102

87106

97597

97598

97602

97605

97606

97606

99070 (IC)

99202

99203

99204

99211

99212

99213

99214

99218

99219

99221

99222

99231

99232

99238

99239

99281

99282

99283

99307

99308

99309

99324

99325

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99349

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

J1020

J1030

J1040

J1710 (IC)

J1720

J3301

J3302

J3303

J3490 (IC)

Q4101 Q4102 Q4103 Q4104 Q4106 Q4107 Q4108 Q4110

S0020

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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](http://www.mass.gov/masshealth). Click on 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](http://www.mass.gov/eohhs/docs/masshealth/providermanual/appx-a-all.pdf) of your provider manual for applicable contact information.

A5500

A5501

A5503

A5504

A5505

A5506

A5507

A5508

A5510

A5512

A5513

L3000

L3001

L3002

L3003

L3010

L3020

L3030

L3031

L3040

L3050

L3060

L3070

L3080

L3090

L3100

L3140

L3150

L3160

L3170

L3201

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L3255

L3257

L3260

L3265

L3300

L3310

L3320

L3330

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L3400

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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

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](file:///C%3A%5CUsers%5Cvborek%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5C0MWO5XZY%5CAppendix%20V) of your provider manual.

This publication contains codes that are copyrighted by the American Medical Association. Certain terms used in the service descriptions for HCPCS codes are defined in the *Current Professional Procedural Terminology (CPT)* codebook.

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