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

MassHealth
Transmittal Letter POD-71
January 2015

TO: Podiatrists Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *Podiatrist Manual* (Updated Gender Dysphoria Policy)

This letter transmits revisions to the podiatrist regulations to reflect changes in coverage of treatment of gender dysphoria.

These amendments are effective for dates of service on or after January 2, 2015.

If you have any questions about the information in 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 4-7, 4-8, 4-15, and 4-16

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Podiatrist Manual

Pages 4-7 and 4-8 — transmitted by Transmittal Letter POD-65

Pages 4-15 and 4-16 — transmitted by Transmittal Letter POD-70

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.

(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;
(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.

424.419: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless

(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (*see* 130 CMR 424.420); and

(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of prescription or over-the-counter drugs or drug therapy:

(1) Cosmetic. The MassHealth agency does not pay for any drug used for cosmetic purposes or for hair growth.

(2) Cough and Cold. The MassHealth agency does not pay for any drug used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient, unless they are dispensed to a member who is a resident of a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR).

(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.

(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.

(5) Less-Than-Effective Drugs. The MassHealth agency does not pay for any drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.

(6) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.

(7) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for any drug when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.

(1) MassHealth covers drugs that are not explicitly excluded under 130 CMR 424.419(B). The limitations and exclusions in 130 CMR 424.419(B) do not apply to medically necessary drugs for MassHealth Standard enrollees under age 21. 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 424.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. *See* 130 CMR 450.303: *Prior Authorization*.

(2) The MassHealth agency 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 charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to gender-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy.

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

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

(5) The MassHealth agency does not pay for any drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307: *Unacceptable Billing Practices*.

424.420: Pharmacy Services: Insurance Coverage

(A) Managed Care Organizations. The MassHealth agency 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 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: *Eligible Members and MassHealth Card* and 450.117: *Managed Care Participation.*

(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 MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency 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) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, *see* 130 CMR 450.101: *Definitions*.

(C) Medicare Part D.

(1) Overview. Except as otherwise required in 130 CMR 406.414(C)(2): *Medicaid Part D One-Time Supplies* and (3): *Cost-Sharing Assistance for MassHealth Members Enrolled in a Medicare Part D Prescription Drug Plan*, for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.