

American Podiatric Medical Association - State Reference Manual
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Services by Podiatrists
April 2012

Introduction: Podiatric Services in Medicaid under Federal Law

Title XIX of the Social Security Act covers Medicaid. Federal Law includes services furnished by physicians under the category of mandatory benefits that states must provide in their Medicaid programs. Physicians are defined under federal Medicaid law as doctors of medicine or osteopathy.

This document is a state-by-state look at Medicaid coverage. This is only intended as an overview, for the most up-to-date and specific information please contact the specific state in question.

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ALABAMA (From: *The Podiatrist Provider Manual; Alabama Medicaid Agency Administrative Code*):

- The Podiatrist Provider Manual states:
 - “Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

“The policy provisions for podiatrists can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.”
- Ch. 11 of the Alabama Medicaid Admin Code touches on podiatry as it relates to EPSDT and states:
 - (e) Podiatrist - Must have a current license issued to practice podiatry, and operate within the scope of practice established by the appropriate state's Board of Podiatry.

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ALASKA (From: *New Medicaid Coverage and Payment Regulations* Effective Feb. 1, 2010):

- EPSDT Podiatry language:
 - (a) The department will pay for a service recommended as a result of the EPSDT screening, if that service is an authorized service under 42 U.S.C. 1396 - 1396w-1.
 - (b) The department will pay for the following additional services for children under 21 years of age if the screening identifies a need for that service:
 1. (1) podiatry services under 7 AAC 110.500 - 7 AAC 110.505;
- (c) The department will pay a physician for providing the following services only if those services are provided to a recipient who is under 21 years of age or who is a Medicare recipient:
 - (1) chiropractic manipulation;
 - (2) podiatry services.
- **7 AAC 110.505. Podiatry services.**
 - (a) The department will pay for the podiatry services and supplies identified in the *CPT Fee Schedule for Podiatry Services* table and *HCPC Fee Schedule for Podiatry Services* table, adopted by reference in 7 AAC 160.900, provided to a Medicaid recipient under 21 years of age who has been found to need medical services relating to specific conditions of the ankle or foot, if a physician has prescribed the treatment; an EPSDT screening under 7 AAC 110.205 has been completed no more than 12 months before or no more than one month after service; and the treatment provided is within the scope of practice of the treating podiatrist who meets the requirements of 7 AAC 110.500.
 - (b) The department will not pay for podiatry services for individuals 21 years of age or older.
 - (Eff. 2/1/2010, Register 193)

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ARIZONA (From: *Arizona Podiatric Services Memo*, April 5, 2010; *AHCCCS Benefit Changes June 1, 2010*; *AHCCCS Benefit Changes FAQs*, Sept. 15, 2010):

As of October 1, 2010, Podiatry services have been eliminated from coverage in Arizona.

- **Population**

- The changes to the benefit package will impact **all** adults 21 years and older. This includes members in the Arizona Long Term Care System and American Indians regardless of whether they receive services through managed care or fee for service.
- Children under the age of 21 will continue to receive the full benefit package available under the Early Periodic Screening Diagnosis and Treatment program.

- **Effective Date and Next Steps**

- Benefit changes will be effective October 1, 2010. Advance notice will be provided prior to implementation of these changes. Updates will be posted to the website as they become available.
- **Benefit Changes:**
 - Services provided by a Podiatrist *Eliminate*

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ARKANSAS (From: *Arkansas Podiatrist Provider Manual*)

142.700 Medicare Mandatory Assignment of Claims for “Physician” Service 1216s and Medicaid’s Mandatory Assignment of Claims for Provider Services

The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for “physician” services furnished to individuals who are eligible for Medicare and Medicaid, including those eligible as Qualified Medicare Beneficiaries (QMBs). According to Medicare regulations, “physician” services, for the purpose of this policy, are services furnished by physicians, dentists, optometrists, chiropractors and podiatrists.

The Arkansas Medicaid Program provides, with limitations, the services listed in Sections 103.100 and 103.200.

201.100 Participation Requirements for Individual Podiatrists

Podiatrists must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. A provider must be licensed to practice podiatry services in his or her state.
- B. A copy of the current state license must accompany the provider application packet.
- C. In order for Arkansas Medicaid to pay for services provided to an Arkansas Medicaid beneficiary who is dually eligible for Medicare and Medicaid, and is provided services that are not covered by both Medicare and Medicaid, the provider must first bill Medicare. The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for services provided by podiatrists. Podiatrists must submit their Medicare provider number to Arkansas Medicaid to ensure the Medicare claims will electronically cross over. To enroll and accept assignment in the Title XVIII – Medicare Program, see Section 202.000.

212.000 Scope

- A. The Arkansas Medicaid Program covers podiatrist services through 42 Code of Federal Regulations, Section 440.60.
- B. Arkansas Medicaid covers podiatrist services for eligible Medicaid beneficiaries of all ages.
- C. Podiatrist services require a primary care physician (PCP) referral.

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- D. Podiatrist services include, but are not limited to, office and outpatient services, home visits, office and inpatient consultations, laboratory and X-ray services, physical therapy and surgical services. Section 242.100 contains the full list of procedure codes applicable to podiatry services.
- E. Many podiatrist services covered by the Arkansas Medicaid Program are restricted or limited.
 - 1. Section 214.000 describes the benefit limits on the quantity of covered services clients may receive.
 - 2. Section 220.000 describes prior-authorization requirements for certain services.

214.200 Medical Visits and Surgical Services

The Arkansas Medicaid Program covers two medical visits per state fiscal year (July 1 through June 30) for medical services provided by a podiatrist in an office, a beneficiary's home or in a nursing facility for eligible beneficiaries age 21 and over. Benefit extensions may be granted in cases of documented medical necessity.

Medical visits for individuals under the age of 21 in the Child Health Services (EPSDT) Program do not have a benefit limit.

Surgical services provided by a podiatrist are not included in the two visits per state fiscal year (SFY) benefit limit for individuals age 21 and over.

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CALIFORNIA (From: *California Welfare and Institution Codes; California Optional Benefits Exclusion; FAQ Optional Benefits that Medi-Cal Will No Longer Cover; OBE: FAQs – Podiatry Services*)

14131.10.

(a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:
(F) Podiatric services.

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) added Section 14131.10 of the *Welfare and Institutions Code* (W&I Code) to exclude several optional benefits from coverage under the Medi-Cal program, effective July 1, 2009.

- **Optional Benefits** The following optional benefits are excluded from coverage under the **Excluded from Coverage** Medi-Cal program:
 - Podiatric services

- **I do not belong to the exempted group of people; is there a way that I can get these benefits through the Medi-Cal Program?**
- Answer: You may still get these benefits as follows:
 - a. If the benefit is part of a Home Health Agency service;
 - b. You have Medicare and these benefits are covered by Medicare Part B;
 - c. The service is provided by a licensed physician;
 - d. The service is provided in a hospital outpatient clinic.

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COLORADO (From: *Colorado Medical Assistance Program – General Provider Information and Requirements; Draft of Colorado Medicaid Benefits Collaborative Policy Statement 1 PODIATRY SERVICES*)

Podiatrist

- Services do not require physician order or physician supervision
- Podiatrists receive direct reimbursement

Re: Co-Payment

Podiatrist Visit \$2.00 per visit

Brief Coverage Statement

Podiatry services are the treatment, prescription for treatment, palliation, correction, or prevention of diseases, ailments, pain, injuries, deformities, or physical conditions of the human toe, foot, ankle, and tendons that insert into the foot by the use of any medical, surgical, mechanical, manipulative, or electrical treatment, including complications thereof, consistent with the generally understood scope of podiatric practice

It may include the suggesting, recommending, prescribing, or administering of any podiatric form of treatment, operation, or healing for the intended palliation, relief, or cure of any disease, ailment, injury, condition, or defect of the human toe, foot, ankle, and tendons that insert into the foot, including complications thereof consistent with such scope of practice, with the intention of receiving, either directly or indirectly, any fee, gift, or compensation

It may include partial amputation of the foot, but it does not involve the complete amputation, or disarticulation between the talus and the tibia, the administration of an anesthetic, other than a local anesthetic, or the surgical correction of clubfoot of an infant two years of age or less. Medically Necessary Routine Foot Care is the cutting or removal of corns and calluses; trimming, cutting, clipping, or debriding of nails; and other hygienic care due to a physical or clinical finding that is consistent with a metabolic, neurological, and/or peripheral vascular disease diagnosis and indicative of severe peripheral involvement.

Coverage Limitations:

1. When a physician or podiatrist provides services to long term care (LTC) facility residents. The referral must result from the resident, an RN, or LPN employed by the facility, the client's

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family, guardian, or attending physician. LTC facilities are responsible for routine foot care and must document the referral in the medical record.

2. Coverage for the debridement and reduction of nails, corns, and calluses are limited to once every 60 days
3. For established patients, a podiatry visit charge must not be billed on the same day as the date for services described for debridement or reduction of nails, corns, and calluses
4. Provider may bill the avulsion and excision codes only once per nail.

CONNECTICUT (From: *Connecticut interChange MMIS Provider Manual Chapter 7 – Podiatrist February 26, 2009; Connecticut Medical Assistance Program PB 2011-69 Policy Transmittal 2011-29*)

Section 17b-262-619. Scope

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Sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of podiatric services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

Sec. 17b-262-622. Eligibility

Payment for podiatric services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

Sec. 17b-262-623. Services covered and limitations

Subject to the limitations and exclusions identified in sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay providers for podiatric services provided by podiatrists:

- (1) for only for those procedures listed in the provider's fee schedule that are medically necessary and medically appropriate to treat the client's condition;
- (2) for podiatric services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;
- (3) for laboratory services provided by a podiatrist in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- (4) for medical and surgical supplies used by the podiatrist in the course of treatment of a client;
- (5) for drugs and supplies administered by a podiatrist;
- (6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation; and
- (7) for EPSDT services including, but not limited to, treatment services which are indicated following screening but not otherwise covered, provided that prior authorization is obtained.

Sec. 17b-262-624. Services not covered

The department shall not pay a podiatrist:

- (1) for information or services provided to a client by a podiatrist over the telephone;
- (2) for any product available to podiatrists free of charge;
- (3) for more than one visit per day per client to the same podiatrist;
- (4) for cosmetic surgery;

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- (5) for simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;
- (6) for simple foot hygiene;
- (7) for repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;
- (8) for repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;
- (9) for an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;
- (10) for cancelled services and appointments not kept;
- (11) for services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies; or
- (12) for any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

Sec. 17b-262-626. Prior authorization

- (a) To receive payment from the department, a podiatrist shall comply with the prior authorization requirements described in section 17b-262-528 of the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.
- (b) Prior authorization, on forms and in the manner specified by the department, shall be required for:
 - (1) physical therapy services in excess of two visits per calendar week per client per podiatrist;
 - (2) physical therapy services in excess of nine visits per calendar year per client per podiatrist, when the therapy is for the treatment of the following diagnoses:
 - (A) cases involving musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and
 - (B) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time;

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- (3) reconstructive surgery;
- (4) plastic surgery;
- (5) EPSDT services that are identified during a periodic screening as medically necessary and which are not listed on the existing fee schedule; and
- (6) other services and supplies identified as requiring prior authorization on the fee schedule.

Recent Update:

Pursuant to Public Act 11-44, Sec. 85(d), effective for dates of service on or after October 1, 2011, Medicaid will cover medically necessary podiatry services for clients 21 years of age and older when such services are performed by enrolled independent podiatrists. This change applies to services reimbursed under the Medicaid fee-for-service program (FFS), the Medicaid for Low Income Adults program (Medicaid LIA), and the HUSKY A program.

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DISTRICT OF COLUMBIA

(From: *DC MMIS Provider Billing Manual*; DC website Medicaid Q & A)

12.1 Podiatrists Eligible to Participate in the DC Medicaid Program

A podiatrist participating in the Medicaid Program in the District of Columbia must be a graduate of a recognized school of medicine and/or osteopathy. Furthermore, he must be licensed to practice medicine, surgery and/or osteopathic medicine and surgery in the jurisdiction in which he practices. It is the responsibility of the podiatrist to maintain a valid license at all times that he is providing services to District Medicaid recipients.

12.3 Definition of Services Reimbursable for Medicaid Patients

These explanations provide the reimbursement guidelines for services rendered to an eligible patient in the podiatrist's private office, the patient's home, or any privately-owned medical facility to the podiatrist. The conditions are not for use by, nor an instrument to provide reimbursement to podiatrist employees of the District of Columbia Government. Services provided in a District of Columbia Government owned facility are not reimbursable to podiatrists unless they are explicitly authorized by the District Director of the Department of Health.

What services does Medicaid cover/include?

- Doctor visits
- Hospitalization
- Ambulatory surgical center
- Medically necessary transportation
- Durable medical equipment
- Emergency ambulance services
- Hospice services
- Laboratory services
- Radiology
- Medical supplies
- Physician services
- Home and Community Based Services (HCBS)

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DELAWARE (From: *Delaware Health and Social Services Division of Medicaid & Medical Assistance Delaware Medical Assistance Program General Policy*)

Non-Covered Services

1.15.1 Some services are generally not covered by the DMAP except if covered by Medicare or are in a managed care organization's benefit package. These services include, but are not limited to:

- Podiatric services. The DMAP will pay for routine foot care ONLY for clients who are diagnosed as having diabetes or circulatory/vascular disorders.

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FLORIDA (From: *Podiatry Services Coverage and Limitations Handbook*)

Podiatrist Qualifications

To enroll as a Medicaid provider, a podiatrist must be licensed as one of the following:

- Podiatrist physician within the scope of the practice as defined in Chapter 461 F.S.; or
- Podiatric physician licensed in the state in which the service is provided.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for information regarding out-of-state providers and services.

Podiatry Services

Medicaid will reimburse podiatrists for medically necessary and reasonable treatment of injuries and diseases of the feet. Foot care, for recipients with medically documented underlying systemic conditions affecting the lower limbs, is also a covered services.

Covered Services

Only the services designated in this chapter and listed in the Podiatry Services Fee Schedule are covered services.

Note: The podiatry Services Fee Schedule is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, then Provider Support, and Fee Schedules.

Excluded Services

The following services are not covered under the Medicaid Podiatry Services Program:

- Podiatry services rendered in a place of service that do not meet the criteria described in the Place of Service and Exception to Place of Service sections of this chapter;
- Treatment of flat foot conditions;
- Cosmetic surgery;
- Experimental or clinically unproven surgeries or treatments; and
- Surgical or non-surgical treatment for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.

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GEORGIA (From: *Georgia Medicaid Policies and Procedures Manual Part II Policies and Procedures for Podiatry Services*)

SPECIAL CONDITIONS OF PARTICIPATION

601. In addition to the general conditions of participation identified in Part I, Section 106, providers in the Podiatry Services Program agree to bill the Division for only those services, which are performed by the podiatrist or under his direct supervision.

For purposes of this policy, only those necessary and appropriate medical services, will be reimburse. The services must me:

- a) the services must be performed by medical personnel who are authorized by law to perform the services and who are qualified by education, training
- b) the person performing the services must be a salaried employee of the podiatrist or of the podiatrist's group practice as defined below; podiatrists may not bill for the services of independent contractors;
- c) the podiatrist must periodically and regularly review the patient's medical records;
- d) the podiatrist must be immediately available on the site at the time the services are delivered;
- e) a podiatrist may not bill for services rendered by a person(s) not approved to provide that service by Medicaid Policy or applicable licensure, certification or other State or Federal Regulation.

The provider must maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances. (See Part I, Chapter 100, Section 105 for General Conditions of Participation.

In a group practice, each podiatrist must enroll separately and only bill for services provided under their own provider number. A group practice is defined as a partnership, a professional corporation, of podiatrists in a space-sharing arrangement. Indiscriminate billing under one podiatrist's name or provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds for disallowing reimbursement. Services performed by non-enrolled podiatrists in a group practice are not covered under any circumstances.

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The common practice of one physician covering for another will not be construed as a violation of this section.

The services furnished by the covering physician is an informal reciprocal arrangement. The regular physician must identify the services as a substitute physician service.

For purposes of this policy, the explanations and limitations contained in Subsection 903.1 shall also apply.

701. There are no special eligibility conditions which members must meet in order to receive podiatric services other than those contained in Part I, Section 102.

801. Services Which Require Prior Approval or Hospital Precertification

As a condition of reimbursement, the Division requires that certain services be approved prior to the time they are rendered. Prior approval from the Division pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. If the service is to be performed in an inpatient hospital setting, precertification is required. Selected services performed in an outpatient hospital or ambulatory surgical center (ASC) setting also require precertification and may also require Prior Approval.

All inpatient hospital admissions, **with the exception of routine deliveries**, require precertification. The attending (admitting) podiatrist is responsible for obtaining the precertification of the hospital admission. The podiatrist's failure to obtain the precertification number will result in denial of payment to all providers billing for services, including the hospital and the attending podiatrist. Certain procedures performed in a hospital or ambulatory surgical center setting require precertification or prior approval. (See Appendix H for the listing of these procedures.) The requirements for obtaining the number will be the same regardless of the site of service. (See Section 804 - Procedure for obtaining Hospital Precertification.) Procedures performed in the office setting do not require precertification but may require Prior Approval.

The Division may require prior authorization of all or certain procedures performed by a specified podiatrist or group of podiatrists based on the findings or recommendations of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or the applicable State Examining Board. This action may be invoked by

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the Commissioner as an administrative recourse in lieu of or in conjunction with an adverse action described in Chapter 400. In such instances, the Division will serve written notice to the provider of this requirement and the grounds for such action.

The medical treatments and services listed in 801.1, 801.2 and 801.3 must be approved prior to the delivery of the service. In emergent, life-threatening situations, the provider must document the emergent condition and forward the claim together with the documentation to the Division's fiscal agent, or obtain precertification or prior approval within thirty (30) calendar days, whichever is applicable.

901. General

"Podiatry services" are defined as the diagnosis, medical, surgical, mechanical, manipulative and electrical treatment limited to ailments of the human foot or leg as authorized within the Georgia statute governing podiatric services.

Federal regulations allow the state agency to place appropriate limits on medical necessity and utilization control. The Division has developed the limitations described in Sections 903 and 904.

The services or groups of services in this Section are covered with limitations. If a podiatrist has special medical justification for exceeding a service limitation, the medical justification should be well documented and made available to the Division upon request.

Such documentation may be requested in a prepayment or post payment review, and lack of appropriate medical justification will be grounds for denial, reduction or recoupment of reimbursement.

904. Non-Covered Services

The following services or procedures are non-covered by the Division. This list is representative of non-covered services and procedures and is not meant to be exhaustive.

- a) Cosmetic Surgery.
- b) Evaluation and non-surgical treatment of a flatfoot condition regardless of the underlying pathology.

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- c) Evaluation of subluxation of the foot and non-surgical measures to correct the condition or to alleviate symptoms.
- d) Routine foot care for ambulatory or bedridden patients including: cutting or removal of corns, warts or callouses; trimming nails and other hygienic and preventive maintenance care; self-care such as cleansing and soaking and the use of skin creams.
- e) Orthopedic shoes other than shoes that are an integral part of a brace.
- f) Orthotic foot devices such as arch supports or biomechanical orthotics.
- g) Vitamin B-12 injections to strengthen tendons, ligaments, etc. of the foot.
- h) Preventive health care (Members under age twenty-one may receive this care through the Health Check screening process. Refer to Appendix E for information on the Health Check Program.)
- i) Drugs used in the podiatrist's office or dispensed by the podiatrist, except those injectables contained in the Division's Physicians Injectable Drug List.
- j) Acupuncture.
- k) All procedures listed in the CPT as "unlisted procedure".
- l) Educational supplies, medical testimony, special reports.
- m) Travel by the podiatrist, no-show or canceled appointments, additional allowances for services provided after office hours or between 10:00 p.m. and 8:00 a.m. or on Sundays and holidays.
- n) Calls, visits or consultations by telephone and other related services.
- o) Routine lab and x-ray services required on hospital admissions.
- p) Biofeedback or hypnotherapy.
- q) Services provided free of charge to Medicaid members by county health departments or state laboratories.
- r) Experimental services or procedures or those which are not recognized by the profession or the United States Public Health Service as universally accepted treatment.
- s) Anesthetic agents other than local therapeutic agents.
- t) Portable x-ray services.
- u) Assistant surgeon for podiatric services.
- v) Anesthesia services of podiatrists other than local J codes (injectables).
- w) Surgical suite.
- x) Amputation performed in a site other than a facility permitted and regulated as a hospital or ambulatory surgical center under Article 1 of Chapter 7 of Letter 31.
- y) Any amputation performed by a podiatrist that is not certified by the Georgia State Board of Podiatry examiners to perform such amputations.

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HAWAII (From: *Hawaii Medicaid Provider Manual Chapter 6: Medical/Surgical Services*)

6.11.1 Description

Medicaid covers medically necessary podiatry services for eligible clients. These services are for ailments or disorders of the foot and ankle when performed by doctors of podiatric medicine (DPM) licensed in the state of Hawaii.

6.11.2 Amount, Duration and Scope

- a) Services and items include but are not necessarily limited to treatment of conditions of the foot and ankle such as:
 - Diagnostic radiology,
 - Surgical procedures,
 - Foot appliances,
 - Orthopedic shoes that are an integral part of a brace,
 - Casts if the casting is for the purpose of constructing or accommodating orthotics, and
 - Ortho-digital prosthesis and casts.
- b) Podiatric services performed in the long-term care facility are limited to diabetic foot care only and must be ordered by the attending physician. “Gang visits” are not allowed. Gang visits” are defined as visits to all/multiple Medicaid recipients in a long term care facility as a result of an attending physician order to treat one recipient in that facility.
- c) Other services in the inpatient hospital require prior authorization.

6.11.3 Exclusions

- a) Routine foot care; including debridement of nails, not related to treatment of infection or injury is not generally considered medically necessary and therefore is not covered with the exception of diabetic foot care in the inpatient hospital or long-term care setting. Routine foot care as defined for the purposes of this policy includes:
 - The cutting or removal of corns or calluses,
 - The trimming of nails (including mycotic nails), and
 - Other hygienic and preventive maintenance care in the realm of self-care, such

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- as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients.
- b) Any services performed in the absence of localized illness, injury or symptoms involving the foot and ankle are not covered.
- c) Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.
- d) The treatment of pes planus (flat feet) is not covered.
- e) Services performed in the home, care home or other non-institutional residence are not covered.

6.11.4 Limitations

- a) All care rendered by podiatrists is limited to the foot and ankle.
- b) Diagnostic radiology procedures are limited to the foot and ankle.
- c) All podiatry services to be provided in the inpatient hospital, outpatient hospital, or long-term care facility must be connected with the diagnosis of diabetes. All other inpatient hospital services not connected with the diagnosis of diabetes require approval by the DHS medical consultant or agent.
- d) Foot and ankle care related to the treatment of infection or injury is covered in the office or outpatient clinic setting.
- e) Bunionectomies are covered only when the bunion is present with overlying skin ulceration, or neuroma secondary to the bunion (neuroma to be removed at the same surgery and documented in the pathology report).

6.11.5 Authorization

- a) Inpatient hospital, outpatient hospital and office surgery codes (10000 – 69999) in excess of \$100 in podiatry charges must be authorized by the DHS medical consultant or agent.
- b) Authorization is required for some non-emergency appliances, refer to the Medicaid fiscal agent for current information.
- c) All other inpatient acute hospital services not connected with the diagnosis of diabetes must be approved for medical necessity by the DHS medical consultant or agent.

From chapter 1 - The services and items covered by the Medicaid Program must be medically necessary for the diagnosis and treatment of the individual client. For services and items to be medically necessary services...

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IDAHO (From: *MEDICAID INFORMATION RELEASE #MA11-12; House Bill 260, Section 9; Idaho Administrative Code: Department of Health and Welfare – IDAPA 16.03.09 Medicaid Basic Plan Benefits*)

Effective for dates of service on and after July 1, 2011, and in compliance with House Bill 260, Section 9, Idaho Medicaid will reimburse podiatrists for preventative care or for treatment of acute foot conditions only if the participant has a chronic condition with vascular restrictions such as diabetes.

Section 9 56-255 (5)(d)

(5) Benefits for all Medicaid participants, unless specifically limited in subsection (2), (3) or (4) of this section, include the following:

(d) Medical care and any other type of remedial care recognized under Idaho law, furnished by licensed practitioners within the scope of their practice as defined by Idaho law, including:

- i. Podiatrists' services based on chronic care criteria as defined in department rule

540. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease.

02. Chronic Foot Diseases. Chronic foot diseases, for the purpose of this provision, include:

- a. Diabetes melitus;
- b. Peripheral neuropathy involving the feet;
- c. Chronic thrombophlebitis; and
- d. Peripheral vascular disease;
- e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or
- f. Other conditions that have the potential to seriously or irreversibly compromise overall health.

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541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.

Participants eligible for podiatrist services are:

01. Participants Who Have a Chronic Disease. Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care.

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ILLINOIS (From: *Illinois Handbook for Providers of Podiatric Services Chapter F-200*)

F-201.1 PARTICIPATION REQUIREMENTS

A provider who holds a valid Illinois (or state of practice) license to practice podiatric medicine is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Residents generally are excluded from participation as the cost of their services is included in the hospital's reimbursement costs. If, by terms of their contract with the hospital, they are permitted to and do bill private patients for their services, participation may be approved.
- Hospital based podiatrists who are salaried, with the cost of their services included in the hospital reimbursable costs, are not approved for participation. Participation may be approved for those podiatrists whose contractual arrangement with the hospital provides for them to make their own charges for professional services.
- Podiatrists holding non-teaching administrative or staff positions in medical schools or hospitals may be approved for participation in the provision of direct services if they maintain a private practice.
- Teaching podiatrists who provide direct services may be approved for participation provided that salaries paid by medical schools or hospitals do not
- include a component for treatment services.

F-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services.

While the various procedure codes listed in the fee schedules are to be used to designate services provided or procedures performed, such listing does not necessarily assure payment. In addition, there are some services usually not covered which may be approved in individual case situations. If a podiatrist believes a service or procedure not usually covered is the most appropriate for a particular situation, a request for prior approval may be initiated. Refer to Section F-211 Prior Approval Requirements. Any question a podiatrist may have about coverage of a particular service is to be directed to the Department prior to provision of the service. See Chapter 100 for addresses and telephone numbers to be used when making an inquiry.

F-204 NON-COVERED SERVICES

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Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services. Additionally, the following podiatry services are excluded from coverage and payment cannot be made for these services:

- Visits and services provided to participants eligible for Medicare benefits if the services are determined not medically necessary by Medicare.
- Services to transitional assistance program participants, except for children 17 years of age and under in the city of Chicago.
- Services provided to participants in long term care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of such facility.
- Preventive or reconstructive services.
- Screening for foot problems.
- Visits by more than one family member on the same day when definitive pathology is not present.
- Provider transportation costs.
- X-rays and laboratory work when not specifically required by the primary condition for which the participant is being treated.
- X-ray and laboratory procedures performed at a location other than the podiatrist's office.
- Surgical assistants or co-surgeons.
- Services which are available from other sources including but not limited to private and governmental agencies.
- Treatment of flat feet, weak feet, pronation, non-involved sprains and strains and minor skin conditions, including services directed toward the care or correction of these conditions.
- Any services billed in association with non-covered services, such as x-ray, laboratory, routine visits, etc.
- Services performed in the absence of localized illness, symptoms or injury involving the foot or toe.
- Repeat surgery performed because the original surgery was not successful.
- Post operative x-rays are covered only as follow-up services subsequent to selected types of surgery or injury. Charges are not to be submitted for more than one plate during the post-operative period (minimum of 30 days), and only when the surgery is one of the surgical procedures subject to the 6 month limitations, or is a follow-up service subsequent to a fracture of the

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- tarsal or metatarsal. Refer to Topic F-224 for details.

F-210.3 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

Federal regulations require that persons less than 21 years of age who have congenital or acquired crippling conditions or conditions leading to crippling, must be referred to the Division of Specialized Care for Children (DSCC) for evaluation.

F-211 PRIOR APPROVAL REQUIREMENTS

Prior to the provision of certain services, and/or dispensing of certain materials, approval must be obtained from the Department.

The approval to provide the service does not include approval of the amount to be paid unless the Department specifies an amount with the approval. The podiatrist and the participant will be advised by the Department of approval or denial of the request.

The following services may be provided only with prior approval of the Department:

- Orthomechanics
- Multiple surgery for bilateral bunion corrections with osteotomies of the first metatarsals
- Surgical procedures within the six-month period following previous surgery. Refer to the fee schedule as referenced in topic F-202.5 for procedures restricted by this limitation.
- Unlisted services

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INDIANA (From: *Indiana Health Coverage Programs Provider Manual*)

Enrollment Process and Cost-Sharing Requirements

Package C has the same application process as the other Hoosier Healthwise benefit packages. A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child's family must pay a monthly premium, as shown in Table 2.2. After the premium is paid, eligibility information is transferred to Indiana.

Enrollment continues as long as premium payments are received and the child continues to meet all eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

The child's family may also be required to make copayments for some services. Providers are responsible for collecting copayments, and the copayment amount is deducted from the claim. Specific information about Hoosier Healthwise Package C member copayments is included in this chapter.

Package C members do not have retroactive eligibility. Package C members may be eligible for coverage no earlier than the first day of the month of application for Hoosier Healthwise.

Hoosier Healthwise Package C provides preventive, primary, and acute healthcare coverage to children younger than 19 years old.

Children enrolled in Package C are eligible for the following benefits:

- Podiatry

The following services have coverage limitations and policies under Hoosier Healthwise Package C that differ from those limitations required by Hoosier Healthwise Package A:

- *Podiatry services:* Surgical procedures involving the foot, which may include laboratory or X-ray services, and hospital stays are covered when medically necessary.

Benefit: Podiatric Services (405 IAC 5-26)

RBMC Reimbursement: Yes (Self-Referral)

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Package A Standard: Surgical Procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.

Package B Pregnancy Coverage: Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services, as well as conditions that may complicate the pregnancy) or urgent care services.

Package C Children's Health Plan: Surgical procedures involving the foot, laboratory, X-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.

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IOWA (From: *Iowa Medicaid State Plan Attachment 3.1 A; 3.1.1-A(6a)*)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law. (*As defined in 42 CFR 440.60*). (*Included below are references to the appropriate professional licensing standards and authority for the practitioners specified*)

a. Podiatrist services are provided with additional limitations described in Attachment 3.1.1-A(6a).

6a. PODIATRIST SERVICES

Iowa Medicaid covers only those medical and remedial care or services provided by a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physician's services when performed by a doctor of medicine or osteopathy.

Additionally, Iowa Medicaid does not cover the following services:

- (f) Treatment of flat foot;
- (g) Treatment of subluxations of the foot; and
- (h) Routine foot care.

Podiatrist services are limited except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions.

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KANSAS (From: *Kansas Medical Assistance Provider Program: Podiatry; Kan Be Healthy Kids PDF*)

KAN Be Healthy Kids

KAN Be Healthy (KBH) is a Medicaid program to help Kansas kids stay in good health. KBH promotes regular screens to help alleviate and treat conditions before they become threatening. Kansas kids must be 20 years of age or younger and have a medical card to participate in KBH.

8400. MEDICAID Updated 04/08

PODIATRY SERVICES ARE COVERED FOR KAN BE HEALTHY (KBH) BENEFICIARIES ONLY.

Adult Care Home:

Podiatry services are not allowed in an adult care home (ACH), except for those services rendered to a KBH beneficiary.

ACH Visits:

One routine visit per month is covered.

No other ACH visits are covered on the same day as an ACH history and physical.

Consultations:

Only one initial consultation is covered within a 60-day period for the same consumer by the same provider.

Only one inpatient follow-up consultation is covered within a 10-day period for the same consumer by the same provider.

Only one outpatient follow-up consultation is covered within a 60 day period for the same consumer by the same provider.

Documentation:

To verify services provided in the course of a postpayment review, documentation in the consumer's medical record must support the service billed.

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Hospital Visits:

One inpatient hospital visit per day is covered.

Only one physician will be reimbursed for a patient with a single diagnosis except for consultation. When a patient has two or more diagnoses involving two or more systems where the special skill of two or more physicians are essential in rendering quality medical care, concurrent care is covered for the days when such care is medically necessary **and** a medical necessity form (Section 4100) is attached.

Office Visits:

One comprehensive office visit is covered per calendar year, per consumer.

Surgery:

Ambulatory/Outpatient Surgery:

Only one ambulatory/outpatient surgical procedure is reimbursed per day, per consumer.

Content of Service:

IVs, medications, supplies and injections performed on the same day as an ambulatory outpatient surgery procedure are considered content of service of the surgery and may not be billed separately.

Anesthesia, equipment and supplies, drugs, surgical supplies, etc., are considered content of service of the ambulatory/ outpatient surgical procedure.

Procedures performed in conjunction with an emergency room visit (sutures, minor surgeries, etc.) are considered content of service of the emergency room visit and may not be billed separately. When reimbursement for the procedure is preferred, the CPT code for the procedure performed shall be billed in lieu of the ER visit.

Cosmetic Surgery:

Surgeries that are cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized. (Refer to Section 4300.)

Elective Surgery:

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The Medicaid Program will not reimburse for elective surgery unless the procedure is medically necessary and the consumer is a KAN Be Healthy participant. (Refer to Section 2020 for details.)

Minor Surgery:

All office visits, hospital visits and non-emergency outpatient visits for a period of 21 days after minor surgeries are content of service of the surgery.

All office visits and non-emergency outpatient visits rendered on the same day as surgery are content of service of the surgery.

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KENTUCKY (From: *Podiatry Program Manual: Kentucky Medicaid Program Podiatry Benefits Policies and Procedures; 907 KAR 1:270. Podiatry Program services*)

Section 1. Coverage. The Medicaid program shall cover a medical or surgical service provided to an eligible Medicaid recipient by a licensed, participating podiatrist if the service falls within the scope of the practice of podiatry except as provided in Section 2 of this administrative regulation.

Section 2. Exclusions From Coverage; Exceptions. Except as provided in this section, the following areas of care shall not be covered:

(1) Routine foot care.

(a) Except as provided in paragraph (b) of this subsection and subsection (2) of this section, a service characterized as routine foot care shall not be covered. Routine foot care shall include:

1. The cutting or removal of a corn or callus;
2. The trimming of a nail; or
3. Other hygienic or preventive maintenance care in the realm of self-care including:
 - a. Cleaning or soaking a foot;
 - b. The use of a skin cream to maintain skin tone of an ambulatory or bedfast patient; or
 - c. A service performed in the absence of localized illness, injury or symptom involving the foot.

(b) If the patient has a systematic disease of sufficient severity that unskilled performance of the following procedures would be hazardous and the patient's condition results from severe circulatory embarrassment or an area of desensitization in a leg or foot, payment shall be made for routine foot care, including the cutting or removing of a:

1. Corn;
2. Callus; or
3. Nail.

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(2) A service ordinarily considered routine shall be covered if the service is performed as a necessary and integral part of an otherwise covered service, including the diagnosis or treatment of:

- (a) A diabetic ulcer;
- (b) A wound; or
- (c) An infection.

(3) A diagnostic or treatment service for a foot infection shall be covered.

Section 3. Incorporation by Reference.

(1) "Podiatry Program Manual", July 1997 edition, Department of Medicaid Services, is incorporated by reference.

(2) It may be inspected, copied, or obtained at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:270, 5-2-86; Am. 18 Ky.R. 1647; eff. 1-10-92; 23 Ky.R. 4241; 24 Ky.R. 385; eff. 7-16-97.)

Section IV [Podiatry Program Manual]

A. COVERAGE

The Medicaid Program shall cover medical and surgical services provided to an eligible Medicaid recipient by a licensed, participating podiatrist if the services fall within the scope of the practice of podiatry except as specified in Section IV, B, (a) or (b). The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.

B. COVERAGE LIMITATIONS

1. Routine foot care.

Services characterized as routine foot care shall generally not be covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot.

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- a. Payment may be made for routine foot care such as cutting or removing corns, calluses or nails if the patient has a systemic disease of sufficient severity that unskilled performance of these procedures would be hazardous; the patient's condition must result from severe circulatory embarrassment or areas of desensitization in the legs or feet.
- b. Services ordinarily considered routine shall also be covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections shall also be covered as they are considered outside the scope of "routine."

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LOUISIANA (From: *Medicaid Services Chart; General Information and Administration Provider Manual; Department of Health & Hospitals State of Louisiana at: <http://new.dhh.louisiana.gov/index.cfm/page/361>*)

Service: Podiatry Services

How to Access Services: *Podiatrist*

Eligibility: All Medicaid recipients.

Covered Services: Office visits. Certain radiology & lab procedures and other diagnostic procedures.

Comments: Some **Prior Authorization**, exclusions, and restrictions apply. Providers will submit request for **Prior Authorization**.

Benefits for Children and Youth

OTHER MEDICAID COVERED SERVICES

- Podiatry Services

MEDICAID RECIPIENTS UNDER THE AGE OF 21 ARE ENTITLED TO RECEIVE THE ABOVE SERVICES AND ANY OTHER NECESSARY HEALTH CARE, DIAGNOSTIC SERVICE, TREATMENT AND OTHER MEASURES COVERED BY MEDICAID TO CORRECT OR IMPROVE A PHYSICAL OR MENTAL CONDITION.

This may include services not specifically listed above. These services must be ordered by a physician and sent to Medicaid by the provider of the service for approval.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- Podiatry Services and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

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MAINE (From: *Mainecare Benefits Manual*)

95.01 DEFINITIONS

95.01-1 Podiatric Care

Podiatric care is a service performed by a licensed podiatrist that is reasonable and medically necessary for the diagnosis or treatment of diseases or pathology of the foot and ankle.

95.01-2 Podiatrist

A podiatrist is a person who has special training and expertise in the diagnosis and treatment of problems associated with the human foot and ankle, and the structures that govern its function. A podiatrist functions within the scope of the current license granted by the State or Province in which the services are performed.

95.01-3 Routine Podiatric Care

MaineCare considers routine podiatric care to include such items as nail debridement, removing corns and calluses, trimming, cutting and clipping of the toenails.

95.01-4 Covered Services

Covered services are those medically necessary services described in Section 95.04.

95.02 ELIGIBILITY FOR CARE

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to furnishing services as indicated in Chapter I of the MaineCare Benefits Manual.

Medical Eligibility Requirements

After an initial visit, podiatric care will only be covered for a member who meets all of the following requirements:

1. Has any illness, diagnosis or condition that if left untreated may cause loss of function or may risk loss of limb; and

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2. For whom self-care or foot care by a nonprofessional person would be hazardous and pose a threat to the member's condition.

95.03 DURATION OF CARE AND LIMITATIONS

Each MaineCare member is eligible for those medically necessary covered services described in this Section. The Department reserves the right to request additional information to evaluate medical necessity.

Some services under this section require prior authorization by the Department or its Authorized Agent. The Department may use criteria outlined in this policy in addition to using prior authorization criteria that is industry recognized prior authorization criteria utilized by a national company under contract. In cases where the criteria are not met, the provider/Member may submit additional supporting evidence such as medical documentation, to demonstrate that the requested service is medically necessary.

95.04 COVERED SERVICES

Covered services are those services provided by podiatrists within the scope of their license and for which the Department may make payment. Covered services include those podiatric services provided directly by a podiatrist, laboratory and x-ray services furnished by the podiatrist's office and services that are specifically included in the Department's MaineCare Benefits Manual, Section 90, Physician Services. Some services require prior authorization by the Department or its Authorized Agent, and procedures requiring prior authorization are listed at: http://portalxw.bisoex.state.me.us/oms/proc/pub_proc.asp?cf=mm . Services shall be covered only for members who meet the medical eligibility requirements in Section 95.02.

Covered services are limited to the following:

95.04-1 Podiatric Care

A. Diagnostic and Treatment Services

The diagnosis and treatment of problems of the foot, in an initial visit in a setting furnished with equipment appropriate to the practice of the profession.

B. Podiatric Care

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Podiatric care will only be covered for members who meet the eligibility above in Section 95.02, Eligibility for Care.

Podiatrists may bill for an office visit, or for podiatric care, but not both for the same visit.

C. Bunion Surgery

The Department requires some bunion surgery to be prior authorized in accordance with provisions defined in Section 90.05-1, Restricted Services, of the MaineCare Benefits Manual, Chapter II, Section 90, Physician Services.

95.04-2 Laboratory and X-Ray Services

MaineCare may reimburse a podiatrist in private practice for laboratory and x-ray services provided in his or her office, using the podiatrist's equipment and supplies. To be eligible for reimbursement, a laboratory and/or x-ray unit must comply with the regulations set forth in Section 55, Laboratory Services and/or Section 101, Medical Imaging Services, in Chapter II of the MaineCare Benefits Manual.

95.04-3 Orthotic Services

MaineCare reimbursement is available to podiatrists in private practice for those orthotic devices covered by MaineCare that are prescribed or utilized within the scope of practice. Podiatrists providing this equipment must inform members of their freedom of choice to obtain these items from other suppliers. MaineCare will not reimburse podiatrists for supplying durable medical equipment to the member unless the durable medical equipment is otherwise unobtainable. MaineCare will not cover orthotics that can be bought off-the-shelf, including those that can be molded. Providers must maintain documentation of acquisition cost, including receipts and a copy of the original invoice, and make such documentation available to the Department upon request. Providers must also maintain documentation supporting the necessity of providing the specialty supplies and/or equipment during the office visit. MaineCare will not reimburse podiatrists for basic medical supplies that are available through providers enrolled as Medical Supplies and Durable Medical Equipment providers. Podiatrists must consult the most recent version of the Current Procedural Terminology (CPT) and the HealthCare Common Procedure Coding System (HCPCS) books for appropriate billing codes. Providers may also consult the Office of MaineCare Services' web site for access to the current procedure codes at: http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html.

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The provider's charges must not exceed acquisition cost. It is also the provider's responsibility to verify that the services and procedure codes are covered by MaineCare. Claims must be submitted according to current Departmental billing instructions. Limits and prior authorization requirements on orthotic services apply as defined in the MaineCare Benefits Manual, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment.

95.04-4 Care for Institutionalized Members

Podiatric care as described above, and/or diagnostic and treatment services provided to a resident of a nursing facility may be reimbursed only when the member meets the medical eligibility requirements set forth in Section 95.02, and a covered service (refer to Section 95.04) is ordered in writing by the member's attending physician, physician assistant, or advanced practice nurse as allowed by the licensing authority and scope of practice.

95.04-5 Interpreter Services

Interpreter services for members who are deaf/hard-of-hearing, or who need language interpreters are to be provided in accordance with the guidelines specified in Chapter I of the MaineCare Benefits Manual.

95.04-6 Supplies and Materials

MaineCare will cover supplies and materials used by a podiatrist for non-routine services needed in performing office procedures that are above and beyond what is usually used in a normal office visit. Examples of supplies and materials are: strapping, padding or compression dressings, plaster, and surgical trays. MaineCare does not cover dressings used following routine podiatric care. MaineCare reimburses acquisition cost only. Claims must be submitted according to current Departmental billing instructions.

95.05 NON-COVERED SERVICES

MaineCare will only cover routine podiatric care for members who meet the medical eligibility requirements in Section 95.02, Eligibility for Care.

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MARYLAND (From: *Code of Maryland Regulations*)

10.09.15 Podiatry Services

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Ambulatory surgical center" means any distinct, Medicare-certified entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.
- (2) "Board" means the State Board of Podiatric Medical Examiners.
- (3) "Department" means the State Department of Health and Mental Hygiene, the single State agency designated to administer the Maryland Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.
- (4) "Emergency services" means treatment for traumatic injury or infection other than athlete's foot or chronic mycotic infection of the nail bed.
- (5) "Hospital" means an institution which falls within the jurisdiction of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01, or other applicable standards established by the state in which the service is provided.
- (6) "Medical Assistance Program" means a program of comprehensive medical and other health-related care for indigent and medically indigent persons.
- (7) "Medically necessary" has the meaning stated in COMAR 10.09.36.01.
- (8) "Medicare" means the insurance program administered by the Federal Government under Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
- (9) "Nursing facility" means a skilled nursing facility certified for participation pursuant to Title XVIII or Title XIX of the Social Security Act, or an intermediate care facility certified for participation pursuant to Title XIX of the Social Security Act, which has entered into a provider agreement with the Department.
- (10) "Personal hygiene care" means routine hygienic care in the absence of pathology.
- (11) "Podiatrist" means a Doctor of Podiatry (D.P.M.) who is licensed to practice podiatry by the Board or by the state in which the service is rendered.
- (12) Practice Podiatry.

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- a. "Practice podiatry" means to diagnose or surgically, medically, or mechanically treat any ailment of the:
 - i. Human foot or ankle;
 - ii. Anatomical structures that attach to the human foot; or
 - iii. Soft tissue below the midcalf.
 - b. "Practice podiatry" does not include:
 - i. Surgical treatment of acute ankle fracture; or
 - ii. Administration of an anesthetic, other than a local anesthetic.
- (13) "Preauthorization" means an approval required from the Department or its designee before rendering services.
- (14) "Program" means the Maryland Medical Assistance Program.
- (15) "Provider" means an individual, association, partnership, or an incorporated or unincorporated group of podiatrists, duly licensed to provide services for recipients, and who, through appropriate agreement with the Department, has been identified as a Program provider by the issuance of an individual account number.
- (16) "Recipient" means a person who is certified as eligible for, and is receiving, Medical Assistance benefits.
- (17) "Routine care" means the cutting or removing of corns and calluses, and the trimming, cutting, clipping, or debriding of toenails.
- (18) "Utilization control agent" means the organization responsible for reviewing the use of medical services to determine medical necessity and lengths of stay according to professional standards.

.03 Conditions for Participation.

- A. General requirements for participation in the Program are that a provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.
- B. Specific requirements for participation in the Program as a podiatry services provider require that the provider:
 - (1) Ensure that all X-ray or other radiological equipment is inspected and meets the standards established by COMAR 10.14.03, or other applicable standards established by the state in which the service is provided;
 - (2) Not knowingly employ another podiatrist to provide services to Medical Assistance patients after that podiatrist has been disqualified from the Program, unless prior approval has been received from the Department.

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.04 Covered Services

The Program covers the following services:

- A. Medically necessary services, when these services are:
 - (1) Rendered to a recipient in the podiatrist's office, the recipient's home, a hospital, nursing facility, a free standing clinic, or elsewhere;
 - (2) Performed by the podiatrist or another licensed podiatrist in his employ;
 - (3) Clearly related to the recipient's individual medical needs as diagnostic, curative, palliative, or rehabilitative services;
 - (4) Adequately described on the recipient's medical record.
- B. Office, home, nursing home, or domiciliary care visits for podiatric care for recipients who are diabetic or who have a vascular disease affecting the lower extremities;
- C. Drugs dispensed by the podiatrist in an emergency or drugs which cannot be self-administered within the limitations of COMAR 10.09.03;
- D. Injectable drugs administered by the podiatrist within the limitations of COMAR 10.09.03;
- E. Medical equipment and supplies prescribed by the podiatrist within the limitations of COMAR 10.09.12; and
- F. Emergency services and related follow-up care.

.05 Limitations.

- A. The Program does not cover the following under this chapter:
 - (1) Services which are not medically necessary;
 - (2) Investigational or experimental drugs or procedures;
 - (3) Services prohibited by the Maryland Podiatry Act or the State Board of Podiatric Medical Examiners;
 - (4) Services denied by Medicare as not medically justified;
 - (5) Drugs and supplies which are acquired by the podiatrist at no cost;
 - (6) Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take oral medications are documented in the patient's medical record;
 - (7) More than one visit per day unless adequately documented in the patient's medical record as an emergency;
 - (8) Visits by or to the podiatrist solely for the purpose of the following:

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- a. Prescription or drug pick-up,
 - b. Collection of specimens for laboratory procedures, except by venipuncture, capillary or arterial puncture, and
 - c. Interpretation of laboratory tests or panels;
- (9) Physical therapy;
 - (10) Orthotics and inlays of any type and related services;
 - (11) Disposable medical supplies;
 - (12) Administration of anesthesia as a separate charge;
 - (13) Corrective shoes;
 - (14) Braces;
 - (15) Personal hygiene care;
 - (16) Routine care, except visits for recipients who are diabetic or who have a vascular disease affecting the lower extremities;
 - (17) Non-surgical hospital visits;
 - (18) Laboratory or X-ray services not performed by the provider or under the direct supervision of the provider; and
 - (19) Podiatric inpatient hospital services rendered during an admission denied by utilization control agent or during a period that is in excess of the length of stay authorized by the utilization control agent.
- B. Routine podiatric care is limited to one visit every 60 days for recipients who have diabetes or peripheral vascular diseases that affect the lower extremities when rendered in the podiatrist's office, the recipient's home, or a nursing facility.
- C. A licensed podiatrist shall perform in a licensed hospital or ambulatory surgical center, subject to the provisions of Health- General Article, §19-351, Annotated Code of Maryland, all surgical procedures of the ankle below the level of the dermis, arthrodeses of two or more tarsal bones, and complete tarsal osteotomies. A licensed podiatrist who performs these procedures in an ambulatory surgical center shall:
- (1) Have current Privileges at a licensed hospital for the same procedures; and
 - (2) Meet the requirements of the ambulatory surgical center.

.06 Preauthorization.

- A. Preauthorization is required for any procedure not included in the current fee schedule.
- B. Preauthorization is issued when:
 - 1. Program procedures are met;

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2. The provider submits to the Department adequate documentation demonstrating that the service to be preauthorized is medically necessary.
- C. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued.
- D. Preauthorization normally required by the Program is waived when the service is covered and approved by Medicare. However, if the entire claim or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing.

Non-Medicare claims require preauthorization according to §§A—C of this regulation.

.07 Payment Procedures.

- A. The provider shall submit his request for payment on the form designated by the Department including all required documentation.
- B. The Department reserves the right to return to the provider, before payment, all invoices not properly signed and completed.
- C. Podiatrists shall bill their usual and customary fees, but they may not bill a fee in excess of that charged the general public for similar services, except for injectable drugs and dispensed medical supplies, in which case podiatrists shall charge the Program the podiatrists' acquisition cost.
- D. The Program shall pay for medically necessary covered services at the lower of the provider's amount billed to the Program or the maximum reimbursement rates set forth on the physicians' fee schedule according to COMAR 10.09.02.07.
- E. The Department will pay for covered services the lower of the following:
 - (1) Podiatrist's customary charge;
 - (2) Department's fee schedule.
- F. Payments on Medicare claims are authorized if:
 - (1) The provider accepts Medicare assignments;
 - (2) Medicare makes direct payment to the provider;
 - (3) Medicare has determined that services were medically justified;
 - (4) Services are covered by the Program;
 - (5) Initial billing is made directly to Medicare according to Medicare guidelines.
- G. Supplemental payment on Medicare claims are made subject to the limitations of the State budget and the following provisions:

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- (1) Deductible insurance will be paid in full;
 - (2) Beginning with August 1, 2010 dates of service, coinsurance shall be paid:
 - a. In full for the following:
 - ii. Mental health services;
 - iii. CPT codes that are priced by report;
 - iv. Claims for anesthesia services;
 - v. Claims from a federally qualified health center; and
 - vi. HCPCS codes beginning with A through W; and
 - b. For all other claims, at the lesser of:
 - i. 100 percent of the coinsurance amount; or
 - ii. The balance remaining after the Medicare payment is subtracted from the Medicaid rate; and
 3. Services not covered by Medicare, but by the Program, according to §E above.
- H. The provider may not bill the Department or the recipient for:
- (1) Completion of forms and reports;
 - (2) Broken or missed appointments;
 - (3) Professional services rendered by mail or telephone;
 - (4) Services which are provided at no charge to the general public;
 - (5) Laboratory or X-ray services not performed by the provider or under the direct supervision of the provider; and
 - (6) Photocopying of medical records when requested by another licensed provider on behalf of the recipient.
- I. The Program will make no direct payment to recipients.
- J. The Program shall reimburse providers for all laboratory services according to the fees established under COMAR 10.09.09.07 and for all radiological services under COMAR 10.09.02.07.
- K. Billing time limitations for claims submitted pursuant to this chapter are set forth in COMAR 10.09.36.

10.09.67.15

.15 Benefits — Podiatry Services.

An MCO shall provide for its enrollees medically necessary podiatry services as follows:

- A. Medically necessary services for enrollees younger than 21 years old;
- B. Diabetes care services specified in COMAR 10.09.67.24; and

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- C. Routine foot care for enrollees, 21 years old or older with vascular disease affecting the lower extremities.

10.09.67.24

.24 Benefits — Diabetes Care Services.

- A. An MCO shall provide to its qualifying enrollees medically necessary diabetes care services as specified in this regulation.
- B. To qualify for the services required by this regulation, the enrollee shall have been discharged from a hospital inpatient stay for a diabetes-related diagnosis.
- C. In addition to the services included in its usual benefits package, an MCO shall provide, at least to the enrollees who qualify under §B of this regulation, the following medically necessary special diabetes-related services:
- (1) Diabetes nutrition counseling, consisting of one initial one-on-one session and up to 4 subsequent sessions annually;
 - (2) Diabetes outpatient education;
 - (3) Diabetes-related durable medical equipment, disposable medical supplies, and therapeutic footwear and related services, when ordered as medically necessary, including:
 - a. Therapeutic footwear, orthopedic shoes, arch supports, orthotic devices, in-shoe supports, elastic support, or examinations for prescription or fitting and related services to prevent or delay a foot amputation that would be highly probable in the absence of the specialized footwear;
 - b. Blood glucose monitoring supplies;
 - c. Diagnostic reagent strips and tablets used in testing for ketones and glucose in urine and glucose in blood;
 - d. Finger-sticking devices used in obtaining blood samples for blood glucose testing; and
 - e. Blood glucose reflectance meters for home use; and
 - (4) Routine foot care.

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MASSACHUSETTS (From: *Commonwealth of Massachusetts Masshealth Provider Manual Series Podiatrist Manual*)

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.

424.405: 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

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(10) shoes when there is no diagnosis of associated foot deformities.

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

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.

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- (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.

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MICHIGAN (From: *Michigan Department of Community Health MSA 10-47 Bulletin – Medicaid Benefits Reinstated; Michigan Department of Community Health Medicaid Provider Manual*)

Pursuant to Public Act 187 of 2010, the Michigan Department of Community Health (MDCH) is reinstating coverage for the adult dental benefit, podiatry, and low-vision eyeglasses and associated services for beneficiaries age 21 years and older.

2. PODIATRY

Effective for dates of service on and after October 1, 2010, MDCH is reinstating podiatry coverage for Medicaid beneficiaries age 21 and older. A \$2.00 co-payment is required for each visit.

SECTION 1 – GENERAL INFORMATION

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Podiatry services

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10.28 PODIATRY SERVICES

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

4.10 FOOT CARE, ROUTINE

Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record and the beneficiary must be receiving regular care from a physician for the systemic disease.

SECTION 23 – PODIATRIST

Medicaid covers the medically necessary services of a podiatrist. (Refer to the MDCH Podiatrist Database on the MDCH website for coverage information.) Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

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MINNESOTA (From: *Minnesota Health Care Programs Provider Manual: Physician and Professional Services*)

Podiatry
Providers

Podiatrists who practice as defined in [MS 153](#) and physicians are eligible for payment for podiatry services.

Covered Services

- Debridement or reduction of pathological toenails, and of infected or eczematized corns and calluses
- Avulsion of nail plate
- Evacuation of subungual hematoma
- Excision of nail and nail bed
- Reconstruction of nail bed
- Other non-routine foot care

Payment Limitations for Debridement or Reduction of Nails, Corns and Calluses

Payment for debridement or reduction of non-pathological toenails, and of non- infected or non-eczematized corns or calluses is limited. These services are considered routine foot care, unless the patient has a systemic condition which may require the expertise of a professional.

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular disease (with synonyms in parenthesis) most commonly represent the underlying conditions which may justify coverage for routine foot care:

- Diabetes mellitus
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, or occlusive peripheral arteriosclerosis)
- Buerger's Disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet associated with:
- Malnutrition and vitamin deficiency

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- Malnutrition (general, pellagra)
- Alcoholism
- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia
- Carcinoma
- Diabetes mellitus
- Drugs and toxins
- Multiple sclerosis
- Uremia (chronic renal disease)
- Traumatic injury
- Leprosy or neurosyphilis
- Hereditary disorders
- Hereditary sensory radicular neuropathy
- Angiokeratoma corporis diffusum (Fabry's)
- Amyloid neuropathy

Non-Covered Services

The following list includes, but is not limited to, podiatry services which are not covered by MHCP:

- Surgical assistant services (differing from assisting surgeons)
- Local anesthetics that are billed as a separate procedure
- Operating room facility charges
- Routine foot care:
 - Foot hygiene (cleaning and soaking the feet to maintain a clean condition)
 - Cutting or removal of corns and calluses (except as noted above)
 - Trimming, cutting, clipping or debriding of nails (except as noted above)
 - Use of skin creams to maintain skin toner
 - Any other service performed in the absence of localized illness, injury or symptoms involving the foot
- Services not covered by Medicare, or services denied by Medicare:
 - Subluxation of the foot
 - Treatment of flat feet
 - Routine foot care
 - Stock orthopedic shoes, except when attached to a leg brace
 - Routine supplies provided in the office. Refer to [List of Routine Supplies section](#).

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Coverage Limitations

The following coverage limitations apply to podiatry services:

- When a physician or podiatrist provides services to long term care (LTC) facility residents:
- The referral must result from the resident, an RN, or LPN employed by the facility, the resident's family, guardian, or attending physician
- The LTC facility must document the referral in the medical record
- LTC facilities are responsible for routine foot care
- Coverage for the debridement and reduction of nails, corns, and calluses are limited to once every 60 days
- For established patients, a podiatry visit charge must not be billed on the same day as the date for services described for debridement or reduction of nails, corns, and calluses
- Provider may bill the avulsion and excision codes only once per nail **Billing**
- Refer to the Billing Policy chapter for Podiatry services billing instructions.
- National foot care modifiers are required on all routine foot care services, regardless of specialty
- Refer to the Laboratory/Pathology, Radiology and Diagnostic Services section for billing instructions

Refer to the RSC-TCM section for Relocation Services Coordination and Targeted Case Management information.

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MISSISSIPPI (From: *Division of Medicaid State of Mississippi Provider Policy Manual*)

Section: 42.08

Routine foot care is defined as the cutting or removal of corns, calluses, and/or trimming of nails (including mycotic nails), and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

Routine foot care is not covered under the Mississippi Medicaid program. Services that normally are considered routine and not covered include the following:

- The cutting or removal of corns and calluses.
- The trimming of nails, including the cutting, clipping, or debridement of ingrown toenails, club nails, or mycotic nails.
- Fungal infections of the nail plates or mycotic nails are common disorders that increase in prevalence with age. A variety of fungal infections produce little or no symptomatology beyond white opacities on the nail. Treatment of this type of fungal infection is considered routine foot care.
- Avulsing small chips after trimming of the thickened/elongated nails that may have been painful, under the diagnosis of ingrown toenail, is considered equivalent to routine foot care.
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury or symptoms involving the foot.
- Foot care such as routine soaking and application of topical medication per a physician's order between required visits to the physician is considered routine foot care.

For routine foot care performed on a beneficiary with a systemic condition, see Section 42.09

Section: 42.09

The definition/coverage of Routine Foot Care is addressed in Section 42.08.

Routine foot care procedures may pose a hazard when performed by a nonprofessional person on patients with a systemic condition that has resulted in severe circulatory

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compromise or areas of desensitization in the legs or feet. The presence of metabolic, peripheral, or neurological disease may require scrupulous foot care by a professional that is considered routine in the absence of systemic conditions.

These foot care procedures, when performed for these conditions, are covered under the Mississippi Medicaid Program.

Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular conditions (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care.

- Diabetes Mellitus
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangitis obliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet that are associated with malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), or pernicious anemia
- Peripheral neuropathies involving the feet that are associated with:
 - carcinoma
 - diabetes mellitus
 - drugs and toxins
 - multiple sclerosis
 - uremia (chronic renal disease)
 - traumatic injury
 - leprosy
 - neurosyphilis
 - hereditary disorders
 - hereditary sensory radicular neuropathy
 - angiokeratoma corporis diffusum (Fabry's)
 - amyloid neuropathy
 - anticoagulant therapy for any reason

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For the above conditions, the patient must be under the active care of an MD/DO for such condition to qualify for covered routine foot care. The active care requirement will be satisfied if the patient has been seen by the attending physician for the condition within the previous six-month period.

The provider must indicate the full name and degree of the treating physician (MD or DO) in item 17 on the CMS-1500 claim form, and the month and year of the last visit in Item 19 on the CMS-1500 claim form. This must also be documented in the medical records. Periodic validation will be made with the treating physician (MD or DO).

Section: 42.22

Non-Invasive Vascular Testing by Doctors of Podiatric Medicine

There are variations in the scope of podiatry practice from state-to-state. The Mississippi law states:

“Diseases and conditions of the feet produced by kidney, heart and other systemic diseases are not to be treated by persons under this Chapter, except under the direction and supervision of a regularly licensed physician of this State.”

Peripheral vascular disease is a systemic condition. The Doppler (other than hand held Doppler which is excluded from coverage) is considered a non-invasive vascular diagnostic test pertaining to a systemic disease and, therefore, out of the scope of the podiatry practice. Patients with a potential surgical problem of the foot with a question of vascular compromise recognized by the podiatrist, should have at the same time the benefit of medical care by a physician trained to diagnose and manage peripheral vascular disease.

Section: 42.24

Exclusions Relating to Foot Care

The following is a list of some of the exclusions under the Mississippi Medicaid program which relate to foot care. While these are the most common exclusions, this is not intended to be a comprehensive list.

- Local anesthesia, digital blocks, or topical anesthesia done with a specific surgical procedure (included in allowance for procedure)
- Orthopedic shoes and supportive devices for the foot

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- Cast application/strapping/splinting billed separately from initial surgery or fracture care on same day as initial surgery or fracture care (initial cast application/strapping/splinting is covered in allowance for initial surgery or fracture care)
- Removal of casts/straps/splints (covered in allowance for original procedure)
- Laboratory services done or ordered by DPM relating to care of systemic conditions
- Fungal cultures on toenail clippings
- Ultrasound for patients with diagnosis of diabetes
- Foot massage
- Whirlpool for mycotic nail treatment
- Routine foot care in the absence of systemic conditions
- Surgical trays
- Supplies
- Biopsies performed in conjunction with a surgical procedure
- Services for treatment of “flat foot”
- Surgical or non-surgical treatment undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity
- Non-invasive vascular testing by Doctors of Podiatric Medicine
- Expanded EPSDT services for children under twenty one (21) years of age for which prior authorization has not been obtained from the Division of Medicaid
- Services performed for conditions “above the ankle” unless within the scope of the provider’s licensure
- Services performed outside of the scope of licensure for the specific physician’s specialty
- Services that are not medically necessary for the diagnosis and treatment of the condition of the foot
- Items or services which are furnished gratuitously without regard to the individual’s ability to pay and without expectation of payment from any source, such as free x-rays provided by a health department
- Cosmetic surgery directed primarily at improvement of appearance and not for correction of defects resulting from trauma, disease, or birth defects
- Routine physician checkups that are not part of the screening program for beneficiaries under twenty one (21) years of age which include examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury
- Immunizations or other preventive health services that are not a part of the screening program for beneficiaries under twenty one (21) years of age and are not related to treatment of injury or direct exposure to a disease such as rabies or tetanus

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- Prosthetic devices and orthopedic shoes for beneficiaries twenty one (21) years of age or older, except for crossover claims allowed by Medicare
- Vitamin injections, except for B-12 as specific therapy for certain anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia; certain gastrointestinal disorders: gastrectomy, malabsorption disorders such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome; certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of the following: multiple sclerosis, trigeminal and glossopharyngeal neuralgia, neuropathies of malnutrition and alcoholism, tabes dorsalis, herpes zoster, and other inflammatory neuritis not due to mechanical or traumatic etiology
- Interest on late pay claims
- Reimbursement for QMBs, except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance
- Reimbursement for any Medicaid service for Specified Low-Income Medicare Beneficiaries (SLMBs) group. They are entitled only to payment of their Medicare Part B premium.

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MISSOURI (From: *Missouri Healthnet General Provider Manual*)

Section 1

MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package. Providers should refer to Section 13 of the applicable provider manual for specific restrictions or guidelines.

Podiatry Services

Section 11

11.6 STANDARD BENEFITS UNDER MO HEALTHNET MANAGED CARE PROGRAM

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

- Limited Podiatry services

11.6. A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than twenty-one (21) years of age. For some members the age limit may be less than nineteen (19) years of age. Some services need prior approval before getting them. Women must be in a MO HealthNet category of assistance for pregnant women to get these extra benefits.

- Podiatry, medical services for your feet;

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MONTANA (From: *Your Healthcare Coverage Montana Medicaid*)

Service: Foot Care (Podiatry)

Covered by Full Medicaid: Yes – Cutting or removing corns or calluses, trimming nails, applying skin creams, measuring and fitting foot or ankle devices, lab services and supplies. Orthopedic shoes are covered for under age 21 or for a person with a brace or device attached to a shoe.

Covered by Basic Medicaid:

Passport Approval Needed: No

Cost Share Needed: Yes-adults

Medicaid Approval Needed: No

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NEBRASKA (From: *Attachment 3.1-A, State Plan Under Title XIX of the Social Security Act, State of Nebraska – Limitations – Podiatrists’ Services*)

Nebraska Medical Assistance Program (NMAP) covers medically necessary podiatry services within the scope of the podiatrists' licensure and within NMAP program guidelines.

ORTHOTIC DEVICES AND ORTHOTIC FOOTWEAR: NMAP covers orthotic devices, orthopedic footwear, shoe corrections, and other items for the feet if medically necessary for the client's condition.

PALLIATIVE FOOT CARE: Palliative foot care includes the cutting or removal of corns or callouses; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory clients; and any services performed in the absence of localized illness, injury, or symptoms involving the foot. Coverage of palliative footcare is limited to one treatment every 90 days for non-ambulatory clients and one treatment every 30 days for ambulatory clients.

Telehealth:

Podiatrists' services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

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NEVADA (From: *Nevada Division of Health Care Financing and Policy: Medicaid Services Manual*)

603.7 PODIATRY

Podiatry services are those services provided by health professionals trained to diagnose and treat diseases and other disorders of the feet. A podiatrist performs surgical procedures and prescribes corrective devices, medications and physical therapy. For Nevada Medicaid recipient's podiatric services are limited to Qualified Medicare Beneficiary recipients and Medicaid eligible children referred as the result of a Healthy Kids (EPSDT) screening examination.

a. Prior Authorization

1. Prior authorization is not required for podiatric office visits provided for children as a direct result of a Healthy Kids (EPSDT) screening examination).
2. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate HCPCS code. Medicaid will pay for the orthotic in addition to the office visit.
3. Prior authorization is not required for Podiatry services provided to a QMB or QMB/MED recipient. Medicaid automatically pays the co-insurance and deductible up to Medicaid's maximum reimbursement after Medicare pays. If Medicare denies the claim, Medicaid will also deny payment.

b. Non Covered Services

Preventive care including the cleaning and soaking of feet, the application of creams to insure skin tone, and routine foot care are not

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covered benefits. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses in the absence of infection or inflammation.

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NEW HAMPSHIRE (From: *Important Notice About Medicaid Service Limits [Oct. 1, 2011]*; *New Hampshire Medicaid Service Notice*; *New Hampshire Medicaid Billing Manual – Podiatry*)

Podiatrist (Foot Doctor) - 4 visits per year (July 1 to June 30)

A visit means all podiatrist services provided on one day by one podiatrist.

RECIPIENT ELIGIBILITY

All NH Medicaid recipients are eligible for podiatry services when the service is performed by a licensed, qualified Podiatrist.

COVERED SERVICES

Podiatric services, provided by a licensed podiatrist, shall be covered for medical and surgical treatments, carried out below the ankle only, for pathological conditions of the foot. Podiatrists bill with procedure codes from the Current Procedural Terminology (CPT) book with one exception:

Code X7420, Type of Service 2, is defined as the destruction of lesion, any method, including laser, with or without surgery below the ankle.

Podiatric visits are limited to 12 services per fiscal year (July 1- June 30). Please be aware that more than 1 service may be provided in a visit.

NON - COVERED SERVICES

- A. Routine foot care, such as preventive care of the feet or the type which is ordinarily considered self-care (i.e., observation and cleansing of the feet, use of skin creams to maintain a skin tone of both ambulatory and bedridden patients); nail care not involving surgery; prevention and reduction of corns, calluses and warts other than by surgery; cutting, paring or removal of corns and calluses; and any services performed in the absence of localized illness, injury or symptoms involving the foot.

- B. Trimming and burring of nails not covered unless:
 - 1. The recipient is confined to a medical care institution (i.e. Nursing Facility).

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2. If the recipient is not confined to a medical care institution and the recipient's physician has certified that the recipient is unable to, or should not care for his/her feet, the physician's statement must be attached to the claim for payment.

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NEW JERSEY (From: *New Jersey Admin. Code*)

§ 8:85-2.11 Podiatry services

- (a) All facilities shall assist Medicaid beneficiaries to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:
 - 1. Appropriate consulting services;
 - 2. In-service education for the facility;
 - 3. Policies concerning foot care; and
 - 4. Routine and emergency services.
- (b) Once the attending physician reviews the consultation and approves the treatment plan of the podiatrist, the physician shall not be required to sign a request every time the podiatrist treats the resident; however, the attending physician shall review and approve the need for the podiatric services for residents under treatment every six months, and if continuing service is indicated, complete a request for podiatric services for each resident under treatment at least once a year. This shall be accomplished by an order on the order sheet and not by repeated requests for consultation.
 - 1. Podiatry services provided to children shall be prior authorized by MDO professional staff.
- (c) Policies and procedures regarding the provision of podiatric services are outlined in the New Jersey Medicaid Program's Podiatry Services Manual

§ 10:57-1.1 Introduction

- (a) This chapter is concerned with the provision of podiatric services by a person licensed to practice podiatry in accordance with the New Jersey Medicaid and NJ FamilyCare programs, policies and procedures and the standards of practice as defined by the laws of the State of New Jersey (N.J.S.A. 45:5-1 et seq.) and the American Podiatric Medical Association.
- (b) An approved New Jersey Medicaid/NJ FamilyCare provider of podiatric services may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid and NJ FamilyCare fee-for-service programs Provider Agreement.
- (c) A podiatrist may enroll in the New Jersey Medicaid and NJ FamilyCare fee-for-service programs and provide covered, medically necessary services as an independent practitioner,

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or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice or under the managed care program.

§ 10:57-1.2 Scope of services

Podiatry care under the Medicaid and NJ FamilyCare programs is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist. For beneficiaries in the Medically Needy Program, podiatry care is only available to pregnant women, and the aged, the blind or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49-2.)

§ 10:57-2.1 Covered and non-covered services

(a) The following foot care services shall not be covered:

1. Flat-foot conditions:
 - i. Exceptions:
 - (1) Treatment which is an integral part of post-fracture or postoperative treatment plan;
 - (2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.
 - ii. Treatment where the talo-crural joint is involved;
 - iii. Treatment where there may be attachment of a supportive device to a brace or bar.
2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):
 - i. Exceptions:
 - (1) Where treatment is an integral part of post-fracture or postoperative treatment plan;
 - (2) Where the talo-crural joint is involved;
 - (3) Where there may be attachment of a supportive device to a brace or bar.
3. Routine foot care, routine hygienic care:
 - i. Exceptions:
 - (1) Treatment of painful corns, calluses and warts;
 - A. When treatments are in excess of one per month, the case must be referred for evaluation to the podiatry unit of the Division of Medical Assistance and

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Health Services, PO Box 712, Mail Code #15, Trenton, New Jersey 08625-0712.

- (2) Treatment of the foot for Medicaid or NJ FamilyCare beneficiaries with metabolic, neurological, and peripheral diseases (for examples, diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombo-phlebitis, peripheral neuropathies); and
- (3) Treatment of fungal (mycotic) and other infections of the feet and toenails.
 - (b) The following guidelines limit the provision of (a)3 above.
 - 1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatry consultant.
 - 2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.
 - 3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot services." Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.
 - 4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

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NEW MEXICO (From: *Healthcare Professional Services – Podiatry Services*)

8.310.11.9 PODIATRY SERVICES: The New Mexico MAD pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for covered services.

8.310.11.12 COVERED SERVICES: MAD covers only medically necessary podiatric services furnished by providers, as required by the condition of the eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and regulations. MAD covers the following specific podiatry services.

- A. Routine foot care when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination and if the severity meets the class findings (as in Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC). An eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of an M.D. or D.O. to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60 calendar days after the routine foot care service. Nurse practitioners, physician assistants and clinical nurse specialists do not satisfy the coverage condition of “active care by a physician”.
- (1) The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:
- a. diabetes mellitus*;
 - b. arteriosclerosis obliterans;
 - c. buerger’s disease;
 - d. chronic thrombophlebitis*;
 - e. neuropathies involving the feet associated with:
 - (i) malnutrition and vitamin deficiency*;
 - (ii) malnutrition (general, pellagra);
 - (iii) alcoholism;
 - (iv) malabsorption (celiac disease, tropical sprue);
 - (v) pernicious anemia;
 - (vi) carcinoma*;

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- (vii) diabetes mellitus*;
- (viii) drugs or toxins*;
- (ix) multiple sclerosis*;
- (x) uremia (chronic renal disease)*;
- (xi) traumatic injury;
- (xii) leprosy or neurosyphilis;
- (xiii) hereditary disorders;
- (xiv) hereditary sensory radicular neuropathy;
- (xv) fabry's disease;
- (xvi) amyloid neuropathy.

(2) Routine foot care services can be covered for an eligible recipient who has a systemic condition that can be covered (as in Subparagraphs (a) through (e) of Paragraph (1) of Subsection A of 8.310.11.12 NMAC) and if the severity meets the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) **class A findings:** non-traumatic amputation of foot or integral skeletal portion thereof.

(b) **class B findings:**

- (i) absent posterior tibial pulse;
- (ii) absent dorsalis pedis pulse;
- (iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness).

(c) **class C findings:**

- (i) claudication;
- (ii) temperature changes (e.g., cold feet);
- (iii) edema;
- (iv) paresthesias (abnormal spontaneous sensations in the feet); or
- (v) burning.

B. Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or

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bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

- C. Treatment of warts on the feet.
- D. Treatment of asymptomatic mycotic nails may be covered in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care. See Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC.
- E. Treatment of mycotic nails is covered in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:
 - (1) marked, significant limitation;
 - (2) pain; or
 - (3) secondary infection.
- F. Orthopedic shoes and other supportive devices only when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.
- G. If the eligible recipient has existing medical condition(s) that would predispose the eligible recipient to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered. All claims related to hospitalization for podiatric procedures are subject to pre-payment or post-payment review.

8.310.11.15 NONCOVERED SERVICES: Podiatric services are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. MAD does not cover the following specific services or procedures.

- A. Routine foot care is not covered except as indicated under “covered services” for an eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:
 - 1. trimming, cutting, clipping and debriding toenails;
 - 2. cutting or removal of corns, calluses, or hyperkeratosis;
 - 3. other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast patients;
 - 4. Any other service performed in the absence of localized illness, injury or symptoms involving the foot.
- B. Services directed toward the care or correction of a flat foot condition. “Flat foot” is defined as a condition in which one or more arches of the foot have flattened out.

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- C. Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.
- D. Surgical or nonsurgical treatments undertaken *for the sole purpose* of correcting a subluxated structure in the foot as an isolated condition are not covered. Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.
- E. MAD will not reimburse for services that have been denied by medicare for coverage limitations.

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NEW YORK (From: *New York state Billing Guidelines – Podiatry; New York State Medicaid Program*)

Services Available Under the Medicaid Program

Under the Medicaid Program, eligible individuals can obtain a wide variety of medical care and services. To acquaint providers with the scope of services available under this Program, the following list has been developed as a general reference.

Payment may be made for necessary:

- services of podiatrists in private practice only for persons in receipt of Medicare or under age 21 with written referral from a physician, physician's assistant, nurse practitioner or nurse midwife.

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NORTH CAROLINA (From: *Division of Medical Assistance: Podiatry Services*)

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to

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correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page.

3.1

General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

3.2 Specific Criteria

The services of a podiatrist are covered for specific diagnoses only. Refer to Attachment A Section B Diagnosis Codes for an approved list of diagnosis codes.

Note: Services of a podiatrist provided to a recipient on that recipient’s first visit to the practice when billed with a new patient office visit code (99201-99205), will not deny for inappropriate diagnosis.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows

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how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Routine foot care is not covered except as indicated in Clinical Coverage Policy #1C-2, *Medically Necessary Routine Foot Care*.

Curettement procedures or shaving of lesions are not covered except as indicated in Clinical Coverage Policy #1C-2, *Medically Necessary Routine Foot Care*.

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NORTH DAKOTA (From: *North Dakota Department of Human Services: Medicaid General Information – Covered Services* available at: <http://www.nd.gov/dhs/services/medicalserv/medicaid/covered.html>; *Guide to North Dakota Medicaid: Primary Care Provider Program*)

Medicaid General Information

Covered Services

Medicaid covers a specific list of medical services. Some covered services have limitations or restrictions. It is a recipient's responsibility to ask a medical provider whether a particular service being provided is covered by Medicaid. Do not assume that all of the medical services you receive are covered and paid by Medicaid. Non-covered medical services are the recipient's responsibility.

The services listed below are a general listing, some covered services have limitations or restrictions.

Podiatry

Covers office visits, supplies, X-rays, glucose and culture checks, and surgery procedures.

Copayments

Under the North Dakota Primary Care Provider Program, you may have to pay part of the cost of your health care. The amount you are responsible for paying is called a copayment. Each time you receive one of the following services, you may have to pay a copayment (*NOTE the exceptions below*). Ask the clinic or hospital if they require you to pay the copayment at the time you receive the service.

\$3 for each Podiatry office appointment

Covered by North Dakota Medicaid: Yes

Requires Referral from Primary Care Provider: No

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OHIO (From: *Ohio Admin Code*)

5101:3-7-01 Eligible Providers of Podiatric Services

MHTL3338-10-01

Effective Date: November 4, 2010

*Most Current Prior Effective Date: **August 15, 2005***

- (A) Definitions.
1. A doctor of podiatric medicine is included within the definition of "physician" but only in respect to functions he or she is legally authorized to perform as defined in section 4731.51 of the Revised Code.
 2. "Podiatric physician" means an individual currently licensed under state of Ohio law or another state's law to practice podiatry.
 3. Interns and residents of podiatric medicine are explicitly excluded from the definition of "podiatric physician" and are covered as part of hospital services. This exclusion applies whether or not the intern or resident may be authorized to practice as a podiatric physician under the laws of the state in which services are performed. Residents having a staff or faculty appointment or designated as a fellow are also excluded from the definition of podiatric physician.
 4. "Podiatric group practice" means a professional association organized under Chapter 1785 of the Revised Code for the purpose of providing podiatric services.
- (B) All podiatric physicians currently licensed to practice podiatry under sections
- (C) 4731.51 to 4731.61 of the Revised Code are eligible to participate in Ohio's medicaid program and provide podiatric medicine services upon execution of an Ohio medicaid provider agreement.
- (D) A professional association (podiatric medicine group practice) is considered eligible to participate in Ohio's medicaid program if it is an association organized under Chapter 1785 of the Revised Code for the purpose of providing podiatric medicine services.
- (E) Podiatric physicians licensed under another state law to practice medicine and surgery are eligible to participate in Ohio's medicaid program and provide covered podiatric medicine services as long as:
1. The services are rendered to eligible Ohio consumers in the state in which the provider is licensed to practice; and
 2. The provider of podiatric medicine services has a current valid provider agreement with the Ohio department of job and family services (ODJFS).

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5101:3-7-02 Podiatric Medicine: Scope of Coverage
MHTL3338-10-01

Effective Date: November 4, 2010

*Most Current Prior Effective Date: **August 15, 2005***

- (A) Podiatric physicians may perform covered services (as defined in Chapter 5101:3-7 of the Administrative Code) which consist of the medical, mechanical and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma. The podiatric physician may also treat the local manifestation of systemic disease as they appear in the hand and foot, but the consumer must be concurrently referred to an eligible prescriber for treatment of the systemic disease itself.
- (B) Podiatric medicine services provided by non-physicians under the direct and general supervision of a podiatric physician are covered in accordance with rule 5101:3-4-02 of the Administrative Code.
- (C) Hospital-based podiatric physicians and surgeons are covered in accordance with rule 5101:3-4-01 of the Administrative Code.
- (D) Podiatric medicine services provided in a teaching setting are covered as set forth in paragraphs (A) to (D)(2), (E)(1) and (F) of rule 5101:3-4-05 of the Administrative Code.
- (E) Podiatric medicine services provided in a long-term care setting are covered as detailed in rule 5101:3-3-19 of the Administrative Code.
- (F) Podiatric medicine services provided by a physician assistant are covered in accordance with rule 5101:3-4-03 of the Administrative Code.
- (G) By report services are covered in accordance with rule 5101:3-4-02.1 of the Administrative Code. In addition, a report must be provided documenting the following:
 - 1. Complete description of the services or procedures;
 - 2. Diagnosis, both preoperative and postoperative;
 - 3. Size, location, and number of lesions;
 - 4. Indication of primary, secondary, or tertiary procedure;
 - 5. The nearest similar current procedural terminology (CPT) code whenever possible;
 - 6. Estimated number of visits for follow-up; and
 - 7. Operative time.

5101:3-7-03 Covered Podiatric Services and Associated Limitations
MHTL3338-10-01

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Effective Date: November 4, 2010

Most Current Prior Effective Date: March 29, 2007

- (A) Visit limitations.
- (1) Visits are covered in accordance with rules 5101:3-3-19 and rule 5101:3-4-06 of the Administrative Code.
 - (2) In addition, the following limitations apply:
 - a. Reimbursable evaluation and management services shall be limited to the following CPT codes:
99201 to 99203
99211 to 99213
99221 to 99222
99231 to 99232
99238
99241 to 99243
99251 to 99253
99304 to 99328
99341 to 99342
99347 to 99348
 - b. Reimbursement by the department is limited to one long term care facility (LTCF) visit per month.
- (B) Therapeutic injections and prescribed drugs are covered in accordance with rule 5101:3-4-13 of the Administrative Code. In addition, vitamin B-12 injections for strengthening tendons, ligaments, or other components of the foot are not covered.
- (C) Surgeries.
- (1) Surgeries are covered in accordance with rules 5101:3-4-09, 5101:3-4-22 and 5101:3-4-23 of the Administrative Code.
 - (2) In addition, the following limitation applies: reimbursement for debridement of nails is limited to a maximum of one treatment within a sixty-day period.
- (D) Laboratory services are covered in accordance with Chapters 5101:3-4 and 5101:3-11 of the Administrative Code.
- (E) Radiology services.
- (1) Radiology services are covered in accordance with Chapters 5101:3-4 and 5101:3-11 of the Administrative Code.
 - (2) In addition, the following radiology services are not covered as podiatric medicine services:

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- (a) Bilateral x-rays when only a unilateral condition or surgery is reported, unless documented as medically indicated;
 - (b) X-rays in excess of three views unless the necessity due to trauma or infection is fully documented;
 - (c) X-rays for soft tissues unless for reasons of infections which is fully documented;
 - (d) Postoperative x-rays unless there is bone involvement necessitating the surgical procedure or cases of suspected postoperative infections; and
 - (e) The use of x-rays or radium for therapeutic purposes.
- (F) Physical medicine services.
- (1) Physical medicine services are covered in accordance with Chapter 5101:3-8 of the Administrative Code.
 - (2) In addition, the following limitations apply:
 - (a) Reimbursement for physical medicine services provided within the scope of practice of podiatric medicine and surgery as specified in the Revised Code is limited to acute conditions only. For those recipients in which the disease has reached a chronic stage, reimbursement will be made only for the periods of acute exacerbation of the disease.
 - (b) Range of motion studies may not be billed separately from an examination of the foot, unless substantiated by a complete report.
- (G) Medical supplies and durable medical equipment (DME).
- (1) A podiatric physician may not be separately reimbursed for medical supplies and equipment (e.g., tape, dressing, or surgical trays) utilized in podiatrist's office, clinic, or patient's home during a podiatric visit.
 - (2) A podiatric physician may be reimbursed for medical supplies and medical equipment dispensed in the podiatric physician's office, clinic or patient's home for use in the patient's home, if the podiatric physician has a "supplies and medical equipment" category of service.
 - (3) The scope and extent of coverage for medical supplies and durable medical equipment, including orthopedic shoes and foot orthoses, are covered in Chapters 5101:3-4 and 5101:3-10 of the Administrative Code.

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OKLAHOMA (From: *Oklahoma Medicaid Fact Sheet; Agreement between Oklahoma Health Care Authority and Podiatrist; Oklahoma Permanent Rules and Executive Orders Effective as of 1-12-12 – 317:30-5-261. Coverage by Category*)

Covered services

- Podiatry services

ARTICLE IV. SCOPE OF WORK

4.0 GENERAL PROVISIONS.

- (a) PROVIDER agrees to provide podiatric services to Medicaid-eligible clients.
- (b) PROVIDER agrees to abide by all restrictions on the practice of podiatry as expressed by the Oklahoma Statutes and Oklahoma Board of Podiatric Medical Examiners rules or the appropriate statutory and regulatory restrictions of the state where services are rendered.
- (c) PROVIDER agrees to comply with all applicable Medicaid statutes, regulations, policies, and properly promulgated rules of OHCA.
- (d) PROVIDER agrees that the state has an obligation under 42 U.S.C. §1396a(25)(A) to ascertain the legal liability of third parties who are liable for the health care expenses of recipients under the care of PROVIDER. Because of this obligation, PROVIDER agrees to assist OHCA, or its authorized agents, in determining the liability of third parties.

317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:

- (1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending

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physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. All outpatient visits are subject to existing visit limitations.

- (2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC 317:30-3-57(a) (20) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.
- (3) **Individuals eligible for Part B of Medicare.** Payment for podiatric services is made utilizing the Medicaid allowable for comparable services.

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OREGON (From: *Oregon Medical-Surgical Services Provider Guide; Medical-Surgical Services Rulebook; Oregon Prioritized List of Health Services January 1, 2012*)

Referrals

Services provided by the following providers require a referral from the PCM:

Podiatrists

All claims requiring a PCM referral must list the PCM's six- or nine-digit Oregon Medicaid provider number in the appropriate box on the claim form.

Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers must follow the Division rules in effect on the date of service.

- (2) The Division enrolls only the following types of providers as performing providers under the Medical-Surgical program:
- a. Doctors of medicine, osteopathy and naturopathy;
 - b. Podiatrists;
- (9) Surgical Assistance -- Payment is restricted to physicians, naturopaths, podiatrists, dentists, nurse practitioners, licensed physician assistants, and registered nurse first assistants:

Line: 172

Condition: PREVENTIVE FOOT CARE IN HIGH RISK PATIENTS (See Guideline Note 76)
Treatment: MEDICAL AND SURGICAL TREATMENT OF TOENAILS AND
HYPERKERATOSES OF FOOT ICD-9: 250.6-250.7,356,357.2,357.5,440.2,443.1
CPT: 11719-11732,11750
HCPCS: G0245-G0247

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PENNSYLVANIA (From: *PA Medical Assistance Manual*)

§ 1143.1. Policy.

The MA Program provides payment for specific medically necessary podiatrists' services rendered to eligible recipients by podiatrists enrolled as providers under the program. Payment for podiatrists' services is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.

§ 1143.21. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for medically necessary podiatrists' services compensable under the MA Program, subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

§ 1143.22. Scope of benefits for the medically needy.

Medically needy recipients are eligible for podiatrists' services compensable under the MA Program, subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

§ 1143.51. General payment policy.

Payment is made for compensable services provided by participating podiatrists subject to the conditions and limitations established in §§ 1143.52—1143.58 and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule. Payment will not be made for a compensable podiatrist's service if full payment as specified in § 1101.62 (relating to maximum fees) is available from another public agency or another insurance or health program.

§ 1143.58. Noncompensable services and items.

1. Payment is not made to a podiatrist for:
 1. Services and items not listed in the MA Program fee schedule.
 2. Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet.
 3. Casting for shoe inserts.
 4. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient.

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5. Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures, signified by the letters OP, which are performed on an inpatient basis unless the requirements specified in Chapter 1150 are met.
6. Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. The podiatrist may not bill the recipient for the disallowed services.
7. Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service.
8. Treatment of flat foot.
9. Treatment of subluxations of the foot.
10. Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care.
11. Physical therapy.
12. Diagnostic or therapeutic procedures for experimental, research or educational purposes.
13. Compensable podiatrist's services if full payment as specified in § 1101.62 (relating to maximum fees) is available from another public agency or another insurance or health program.
2. Payment is not made for the following items, even if they are prescribed by a podiatrist:
 14. Tennis shoes, sneakers, slippers, sandals or another type of footwear that does not fit the description of the orthopedic or molded shoe established in § 1143.2 (relating to definitions).
 15. Shoe inserts for orthopedic or molded shoes.
 16. Modifications to orthopedic or molded shoes, except those modifications necessary for the application of a brace or splint.
 17. Modification to or repair of nonorthopedic shoes other than for insertion of shoe inserts.
 18. Orthopedic shoes recipients 21 years of age or older.

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PUERTO RICO (From: *Puerto Rico Medicaid Supplemental Attachments*)

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services

.....X....._ Provided _____ No limitations - **X With** limitations* _____ Not Provided

6a. Podiatrist services are provided as remedial and incidental care rendered for attending special conditions under the Health Refom1 Plan's special coverage.

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RHODE ISLAND (From: *Podiatry Coverage Policy: Provider Participation Guidelines*)

Reimbursement Guidelines

The reimbursement rates for Podiatrists are listed in the Fee Schedule. Providers must bill the Medical Assistance Program at the same usual and customary rate as charged to the general public and not at the published fee schedule rate. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to the Medical Assistance Program.

Covered/Non Covered Services

Only Categorically Needy (CN) and EPSDT program recipients are eligible for podiatry services. These recipients can be identified through the Recipient Eligibility Verification System (REVS). The Medical Assistance Program covers routine foot care, such as debridement of nails and treatment for ingrown toenails. All covered procedure codes for podiatry services are listed in the fee schedule.

Medicare/Medicaid Crossover

The Medical Assistance Program reimbursement for crossover claims is always capped by the established Medical Assistance Program allowed amount, regardless of coinsurance or deductible amounts. The standard calculation for crossover payments is as follows:

The Medical Assistance Program will pay the lessor of:

The difference between the Medical Assistance Program allowed amount and the Medicare Payment (Medical Assistance Program allowed minus Medicare paid); or The Medicare coinsurance and deductible up to the Medical Assistance Program allowed amount, calculated as follows: (Medicare coinsurance/deductible plus Medicare paid) – (Medical Assistance Program allowed).

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SOUTH CAROLINA (From: *South Carolina Health and Human Services – What Services are Covered?; Medicaid Bulletin [Dec. 14, 2010]*)

What Services Are Covered?

Within certain limits, Medicaid will pay for services that are medically necessary. In addition, some services are limited to a certain number during the state fiscal year. (The state fiscal year runs from July 1 through June 30 of the following year.) **Medicaid can pay for the following medical services:**

16. Podiatrists' Services – Medicaid will pay for diagnosis and treatment of foot conditions not associated with routine foot care.

To: Medicaid Providers
Subject: Medicaid Reductions

The South Carolina Department of Health and Human Services (SCDHHS) projects a budget shortfall of \$228 million during the current fiscal year. This is a result of a combination of significant enrollment increases and budget reductions. In order to safeguard the financial viability of the Medicaid program and meet statutory requirements for the operation of Medicaid, SCDHHS must take prompt action to contain Medicaid costs. Current state and federal restrictions largely limit the agency's ability to make reductions apart from reducing optional state Medicaid services.

Below is a list of upcoming changes. Additional Medicaid Bulletins may be issued to provide further details. To learn more about South Carolina's Medicaid budget, current restrictions and to offer cost-saving suggestions, please visit <http://msp.scdhhs.gov/msp>.

1. **The following eliminations are effective for dates of service on or after February 1, 2011:**

Discontinue Coverage of Podiatry services for adults

SCDHHS will discontinue coverage of Podiatric services for beneficiaries over the age of 21.

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SOUTH DAKOTA (From: *Covered Podiatry Surgical Procedures; Covered Podiatry Non-Surgical Procedures; 67:16:07:04. Services Not Covered; South Dakota Medical Assistance Program Professional Services Manual*)

67:16:07:04. Services not covered. In addition to other services not specifically covered under § 67:16:07:03, the following podiatry services are not covered under the medical assistance program:

- (1) Stock orthopedic shoes unless they are covered under chapter 67:16:11 for children under age 21 or a shoe is built into a leg brace;
- (2) Treatment of flatfoot;
- (3) Surgical or nonsurgical treatment of subluxations of the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity. This does not include surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an inducted or associated symptomatic condition;
- (4) Routine foot care including cutting or removing corns or calluses, unless infected or eczematized; trimming nails, including mycotic nails; providing hygienic and preventive maintenance care, such as cleaning and soaking the feet; using skin creams to maintain skin tone of both ambulatory and bedfast patients; and providing services in the absence of localized illness, injury, or symptoms involving the foot, such as routine soaking and application of topical medication on the physician's order between required visits to the physician;
- (5) Treatment of a fungal (mycotic) infection of the toenail unless there is clinical evidence of mycosis of the toenail and compelling medical evidence documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, if nonambulatory, the patient has a condition that is likely to result in significant medical complication in the absence of treatment; and
- (6) Podiatry services not covered under Medicare or denied by Medicare as not medically necessary.

COVERED SERVICES

Covered podiatry services are located on the department's website at <http://dss.sd.gov/sdmedx/includes/providers/feeschedules/dss/index.aspx>.

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NON-COVERED SERVICES

In addition to other services not specifically listed in the covered services section of Administrative Rule, podiatry services not covered under the Medical Assistance Program are located at ARSD § 67:16:07:04.

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TENNESSEE (From: *TennCare Medicaid and TennCare Standard Policy Manual; Rules of Tennessee Department of Finance and Administration Bureau of TennCare Chapter 1200-13-1 General Rules*)

Allowable Medical Expenses

The following is a specific description of the types of medical expenses considered “allowable Medical Expenses” and for which a deduction for payment is allowed in spending down excess income in MN cases:

- **Doctor’s fees** - Practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, Christian Science.

Qualifying Expenses

Allow deductions for payment of the following types of medical expenses as Item D’s:

- **Doctors’ Fees** - Fees for physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, chiropodists, podiatrists, psychiatrists, psychologists, Christian Science practitioners and others for medical services are allowable deductions if incurred during periods of Medicaid/TennCare ineligibility.

Acceptable Medical/Mental Health Information Sources

Evidence from acceptable medical/mental health sources is needed to establish whether an individual has a medically determinable impairment. Acceptable medical and mental health information sources are:

- Licensed podiatrists for purposes of establishing impairments of the foot, or foot and ankle, depending on whether the state in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle

(hh) Podiatry services will be covered. Services are to be provided within the podiatrist’s license to practice. Office visits will be limited to two (2) per recipient per fiscal year. These visits will count toward the limit on office visits as specified in rule 1200-13-1-.03(l)(g)l.

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TEXAS (From: *Texas State Medicaid Plan Attachments; Texas Medicaid Benefits Manual*)

6a. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Podiatrist services Provided No Limitations

6.a. Podiatrists' Services

Services include those provided by a licensed podiatrist, that are within the scope of practice of the profession as defined by state law and covered by medicare.

The state may choose to provide some, all, or no optional services specified under federal law. Some optional services Texas chooses to provide are available only to clients under age 21, and one optional service (IMD) is available to clients who are under 21 or 65 and over. (If the person is under age 21, all federally allowable and medically necessary services must be provided as required under federal law.) Optional and mandatory services provided in Texas include:

Acute Care Services:

Optional: Medical care or remedial care furnished by other licensed practitioners

- Podiatry

Medicaid clients eligible for limited benefits include:

Medicare Beneficiaries - Based on income level and age, certain Medicare beneficiaries qualify for partial Medicaid benefits.

Dual Eligibles

Dual eligibles are individuals who qualify for both Medicare benefits and Medicaid assistance. They are a subset of the Aged and Disabled population. Medicare is a federally-paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D). Medicaid pays for all or a portion of Medicare Part A and B premiums, co-payments, and deductibles for dual eligibles.

Full Dual Eligibles

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Full dual eligibles are Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the deductible and co-insurance for Medicare services and may cover other Medicaid services not covered by Medicare, such as long-term services and supports. As a result of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, Medicare assumed responsibility for most prescription drug coverage for dual eligibles in 2006. As of August 2010, there were 349,327 full dual eligible clients in Texas.

Partial Dual Eligibles

Medicaid also provides limited assistance to certain Medicare beneficiaries, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. As of August 2010, there were 215,845 partial dual eligibles in Texas.

UTAH (From: *Utah Medicaid Provider Manual: Podiatric Services*)

1 PODIATRIC SERVICES

Podiatric services are optional services. However, podiatric services are mandatory for individuals eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) also known in Utah as Child Health Evaluation and Care (CHEC).

The purpose of the podiatry program is to increase the functioning ability of the Medicaid recipient. Podiatric services include the examination, diagnosis and treatment of the human foot through medical, mechanical, or surgical means. Services may be performed by a physician, osteopath, or podiatrist as specified by the respective professional license.

3 COVERED SERVICES

Covered podiatric services are limited to examination, diagnosis, and treatment described in this chapter.

3 - 1 Podiatric Services

Podiatric services include the following:

- Foot incision
- Foot excision
- Repair, revision or reconstruction
- Nail treatment, subject to limitations described in Chapter 4, Limitations.
- Radiology

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- Reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendinitis, and other related conditions that result from, or are associated with, partial displacement of foot structures.
- Surgical correction in the subluxated foot structure only when it is an integral part of the treatment of a foot injury.
- Surgical correction undertaken to improve the function of the foot or to alleviate an associated symptomatic condition is also a covered service.
- Medical supplies and materials used by the podiatrist over and above those usually included for the surgical procedure.

3 - 2 Shoes and Shoe Repair

- A. Shoes are a Medicaid Benefit only when:
1. attached to a brace or prosthesis; or
 2. especially constructed to provide for a totally or partially missing foot. The previous amputation must be documented and diagnosis of diabetes with previous foot ulcerations.
- B. Shoe repair is covered only when it relates to external modification of an existing shoe to meet a medical need, for example, leg length discrepancy requiring a shoe build up of one inch or more.

4 LIMITATIONS

Limitations which apply to services provided by a physician or osteopath also apply to services provided by a podiatrist.

1. Treatment of a fungal (mycotic) infection of the toenail is covered if there is documented clinical evidence of mycosis that causes limitation of ambulation or pain.
2. A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.
3. Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (office call) procedure code.
4. Podiatry services for recipients residing in long term care facilities have the following limitations:
 - (a) Foot care performed by an employee of the facility is not covered.
 - (b) Visits are limited to one visit every 60 days.
 - (c) Debridement of mycotic toenails is limited to once every 60 days.
 - (d) Trimming corns, warts, calluses or nails is limited to once every 60 days.
 - (e) Podiatrist visits (evaluation and management) are not covered, only the actual services

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5 NON-COVERED SERVICES

Any service not listed as covered is not a Medicaid benefit. The following services are not covered:

1. Preventive maintenance, routine foot care, ordinarily within the realm of self care or nursing home care considered to be routine is not a benefit. This includes:
 - A. The removal of corns, warts or calluses unless a danger to the patient exists (for example: diabetes, arteriosclerosis or Buerger's disease).
 - B. The trimming, cutting, clipping, or debriding of nails (including mycotic nails).
 - C. Other hygienic and preventive maintenance care, such as cleaning and soaking of the feet, the use of massage or skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness or injury.
 - D. Any application of topical medication or any treatment of fungal (mycotic) infection of the toenail, except when there is limitation to ambulation or pain.
2. Supportive devices including arch supports, orthotics, or metatarsal head appliances are not a benefit.
3. Treatment and evaluations of subluxation or flat feet is not a benefit.
 - A. The treatment, including evaluation, of subluxations of the feet. These are structural misalignments, or partial dislocation (other than fractures or complete dislocations) of the joints of the feet which require treatment only by nonsurgical methods regardless of underlying pathology.
 - B. The treatment, including evaluations and the prescriptions of supporting devices, of the local condition of flattened arches regardless of the underlying pathology.
4. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need, i.e., leg length discrepancy requiring a shoe build up of one inch or more.
5. Internal modification of a shoe is not a benefit.
6. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.
7. Special shoes such as:
 - A. mismatched shoes (unless attached to a brace);
 - B. shoes to support an overweight individual;
 - C. trade name or brand name shoes considered "orthopedic" or "corrective";
 - D. "athletic" or "walking" shoes.
8. Arch supports, foot pads, metatarsal head appliances or foot supports.

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9. Personal comfort items and services. Comfort items include, but are not limited to arch supports, foot pads, “cookies” or other accessories, shoes for comfort or athletic shoes.
10. The manufacture, dispensing, or services related to orthotics of the feet.

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VERMONT (From: *Department of Vermont Health Access Medicaid Covered Services Rules*)

7308 Podiatry Services (12/01/1980, 80-62)

Covered podiatry services performed by a licensed podiatrist or chiropodist within the scope of his license or by any other physician are limited to non-routine foot care; such as, surgical removal of ingrown toenails, treatment of foot lesions resulting from infection or diabetic ulcers, and similar Medicare covered services. This includes services in connection with covered treatment according to policy applicable to all physicians' services.

The following routine foot care services are excluded, regardless of who performs them (podiatrist, physician, surgeon, etc.):

- Treatment of flat foot conditions and supportive devices used in such treatment; and
- Treatment of subluxations of the foot (structural misalignments of the joints of the feet) not requiring surgical procedures (i.e., treatment by strapping, electrical therapy, manipulations, massage, etc.); and
- Curring or removal of corns or calluses, trimming of nails and preventive or hygienic care of the feet.

The fact that an individual is unable, due to physical disability, to perform routine foot care services for himself does not change the character of the services and make them "non-routine".

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VIRGINIA (From: *Virginia Medicaid Provider Manual – General; Podiatry Services Manual - Covered Services and Limitations*)

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- Podiatry services

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Podiatry services;

OVERVIEW

This chapter describes the coverage available to Department of Medical Assistance Services (DMAS) recipients for podiatry services. A description of covered and non-covered podiatry services, as well as the limitations that have been imposed on covered services, is included.

COVERED SERVICES

Podiatry Services

Covered podiatry services are defined as reasonable and necessary diagnostic, medical, surgical (mechanical, physical, and adjunctive) treatment of disease, injury, or defects of the human foot. Amputation of the foot or toes is not covered.

Non-Covered Services

The following laboratory and X-ray services are specifically **EXCLUDED** from coverage and payment:

- Services performed on a routine basis but not medically indicated by the patient's symptoms.

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- Laboratory test professional component (Modifier A) for procedures performed in the office, outpatient hospital, or in the independent laboratory. Payment for **supervision** and **interpretation** is included in the full procedure payment.
- Sensitivity studies when a culture shows no growth. Payment will only be made for the culture.
- X-ray procedure professional component (Modifier A) for procedures performed by an independent laboratory (portable X-ray service) or another physician performing a complete procedure. "Modifier E" is to be used by the physician billing only for the use of radiology equipment (technical component). The technical component can only be billed in conjunction with another physician billing **only** for professional components.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

[Effective Date: January 1989]

The Medicare Catastrophic Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible only for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY- QMB- MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." Medicaid does not make payment for any recipient of this group for pharmacy, non-emergency transportation, medical supplies, or any service not covered by Medicare.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

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Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

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WASHINGTON (From: *Washington Medicaid State Plan – Attachment 3: Services: General Provisions*)

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: No limitations With limitations*

6. Other Practitioners Services

Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law

a. Podiatrists' Services

(1) Foot care is covered only for specific medical conditions that must be treated by a podiatrist.

(2) Foot conditions for which treatment is not medically necessary (e.g. the treatment of flat feet, treatment of superficial fungal infection of the skin or nail, bunions, or hammertoes) are not covered.

(3) Reimbursement is according to Attachment 4.19-B III. Physicians' Services.

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WEST VIRGINIA (From: *Department of Health and Human Resources – Chapter 508 Podiatry Services*)

520.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

Podiatric Services - The foot and ankle services provided by a podiatrist licensed to provide such services in the State of West Virginia. For provision of ankle surgery, the podiatrist must have hospital privileges granted by the hospital's medical staff credentialing committee.

520.4 DESCRIPTION OF COVERED SERVICES

The Bureau will reimburse podiatrists for the following medically necessary and appropriate foot and ankle care services provided to eligible West Virginia Medicaid members:

- Treatment services for acute conditions such as infections, inflammations, and ulcers
- Surgeries for such conditions as bunions, exostoses, hammertoes, neuromas, and ingrown toenails.
- Reduction of fractures and dislocations of the foot and ankle, if specific requirements outlined in Section 520.5.1 are met
- Surgical correction of a subluxated foot structure is covered if:
 - It is an integral part of the treatment of a foot injury
 - It is performed to improve function of the foot
 - It alleviates an induced or associated symptomatic condition.
- Treatments of symptomatic conditions associated with partial displacement of the foot are covered. Symptomatic conditions include:
 - Osteoarthritis
 - Bursitis
 - Bunions
 - Tendonitis
- Treatment of sprains and strains.
- Treatment of plantar warts.
- Orthotics necessary for treatment of the feet and limited to the following items:

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- Footrest, removable, molded to member model
- Orthopedic footwear, custom molded shoe, removable inner mold, orthotic shoe, and modifications
- Therapeutic shoes and inserts for members with severe diabetic foot disease and provided for the purpose of averting amputation.
- Consultations for further evaluation and management of the member as requested by a licensed practitioner, including a written report to the requesting practitioner (usually the member's attending practitioner).
- Evaluation and management services and covered treatment services provided to members who are inpatients of a hospital.
- Covered treatment/surgical services provided to members who are residents of a nursing home except screening services.
- Non-invasive peripheral vascular studies are covered for pre-operative evaluation of members with diabetes or other signs of peripheral vascular disease (93922, 93923, 93925, 93926).

520.5 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

The following limitations apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

520.5.2 ROUTINE FOOT CARE SERVICES

Reimbursement for medically necessary and medically appropriate routine foot care services is limited and contingent on the following:

- Must have referral from treating practitioner who has treated patient within six months.
- The member, under the active care of a practitioner, including inpatient hospital and nursing home residents, must have one or more of the following diseases or systemic conditions, along with documented evidence that unskilled care would be harmful to the member:
 - Diabetes mellitus.
 - Chronic thrombophlebitis.

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- Peripheral neuropathies involving the feet related to malnutrition, alcoholism, malabsorption (celiac disease, tropical sprue) or pernicious anemia, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, chronic renal disease, traumatic injury, neurosyphilis, hereditary sensory radicular neuropathy, angiokeratoma corporis diffusum and amyloid neuropathy.
- Arteriosclerosis of the extremities.
- Thromboangiitis obliterans or Buerger's disease.
- In addition to the above covered diagnoses, the severity of the condition must be established and supported by clinical findings in conjunction with the practitioner, as follows:
 - Class A:
 - A finding of "non-traumatic amputation of foot or integral skeletal portion."
 - Class B:
 - Or, any two findings of:
 - $\frac{3}{4}$ Absent posterior tibial pulse
 - $\frac{3}{4}$ Advanced trophic changes, such as decrease in hair growth, nail thickening, discolorations, thin or shiny texture and reddening of skin color (three of these required)
 - $\frac{3}{4}$ Absent dorsalis pedis pulse.
 - Class C:
 - Combination of one from Class B and two from Class C or, one finding from the preceding list and two findings of:
 - $\frac{3}{4}$ Claudication
 - $\frac{3}{4}$ Temperature changes, such as cold feet
 - $\frac{3}{4}$ Edema
 - $\frac{3}{4}$ Abnormal spontaneous sensations in the feet
 - $\frac{3}{4}$ Burning

When billing for the above services, use the appropriate modifier from the list below:

Q7 One Class A finding.

Q8 Two Class B findings.

Q9 One Class B and two Class C findings.

- Podiatrists must obtain and document:

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f The name of the practitioner who has seen the member within the last six months, and with a diagnosis previously provided.

f The name of the practitioner presently in charge of the member's care if not the same as the referring practitioner.

520.6 NON-COVERED SERVICES

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, the following services are not covered:

- Treatment and supportive devices for flat foot conditions, regardless of underlying pathology.
- Treatment of subluxations of the foot; i.e., correcting a subluxated structure in the foot as an isolated entity.
- Routine foot care performed in the absence of localized illness, injury, or symptoms involving the foot. (See 520.5.2)
- Therapeutic shoes, inserts and/or modifications that are provided to members who do not meet the coverage criteria.
- Consultations or visits when the sole purpose of the encounter is to dispense or fit the shoes.
- Deluxe features of any kind.
- Telephone calls/consultations, including but not limited to, information or services provided to a member or on her/his behalf.
- Services/items for the convenience of the patient or caretaker.
- Failed appointments, including, but not limited to, missed or canceled appointments.
- Time spent in preparation of reports.
- A copy of medical report when the DHHR or the Bureau paid for the original service.
- Experimental services or drugs.
- Research/study projects.
- Services/items that are not least costly that will meet patient's medical needs.
- Services rendered outside the scope of a provider's license.
- Treatment in podiatrist's office, etc. when patient is able to do self care at home.
- Denial of services by a primary payer for "not medically necessary" or "deemed not medically necessary."
- Conscious sedation, local anesthesia, regional anesthesia, IV sedation are non-covered. These are included in the procedure/service being provided.

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WISCONSIN (From: *BadgerCare Plus and Wisconsin Medicaid Covered Services Comparison Chart*; *ForwardHealth – Your Connection to Health Care Coverage and Nutrition Benefits*; *Wisconsin Department of Health Services – Ch. 107 Covered Services*)

Service: Podiatry

Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid: Full coverage. \$.50 to \$3.00 copayment per service, limited to \$30.00 per provider per calendar year.

Coverage Under the BadgerCare Plus Benchmark Plan: Full coverage. \$15.00 copayment per visit.

Coverage Under the BadgerCare Plus Core Plan: Full coverage. \$0.50 to \$3.00 copayment per service, limited to \$30.00 per provider per enrollment year.

Coverage Under the BadgerCare Plus Basic Plan: Full coverage, although certain visits are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers:

- Chiropractors
- Nurse practitioners
- Physicians (including psychiatrists and ophthalmologists)
- Physician assistants
- Podiatrists

There is a \$10.00 copayment per visit.

DHS 107.14 Podiatry Services

(1) COVERED SERVICES.

(a) Podiatry services covered by medical assistance are those medically necessary services for the diagnosis and treatment of the feet and ankles, within the limitations described in this section, when provided by a certified podiatrist.

(b) The following categories of services are covered services when performed by a podiatrist:

1. Office visits;
2. Home visits;
3. Nursing home visits;
4. Physical medicine;
5. Surgery
6. Mycotic conditions and nails;

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7. Laboratory;
8. Radiology;
9. Plaster or other cast material used in cast procedures and strapping or tape casting for treating fractures, dislocations, sprains and open wounds of the ankle, foot and toes;
10. Unna boots; and
11. Drugs and injections

(2) OTHER LIMITATIONS.

- (a) Podiatric services pertaining to the cleaning, trimming and cutting of toenails, often referred to as palliative or maintenance care, shall be reimbursed once per 61 day period only if the recipient is under the active care of a physician and the recipient's condition is one of the following:
 1. Diabetes mellitus;
 2. Arteriosclerosis obliterans evidenced by claudication;
 3. Peripheral neuropathies involving the feet, which are associated with:
 - a. Malnutrition or vitamin deficiency;
 - b. Diabetes mellitus;
 - c. Drugs and toxins;
 - d. Multiple sclerosis; or
 - e. Uremia;
 4. Cerebral palsy;
 5. Multiple sclerosis;
 6. Spinal cord injuries;
 7. Blindness;
 8. Parkinson's disease;
 9. Cerebrovascular accident; or
 10. Scleroderma.
- (b) The cutting, cleaning and trimming of toenails, corns, callouses and bunions on multiple digits shall be reimbursed at one fee for each service which includes either one or both feet.
- (c) Initial diagnostic services are covered when performed in connection with a specific symptom or complaint if it seems likely that treatment would be covered even though the resulting diagnosis may be one requiring non-covered care.

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- (d) Physical medicine modalities may include, but are not limited to, hydrotherapy, ultrasound, iontophoresis, transcutaneous neurostimulator (TENS) prescription, and electronic bone stimulation. Physical medicine is limited to 10 modality services per calendar year for the following diagnoses only:
 - 1. Osteoarthritis;
 - 2. Tendinitis;
 - 3. Enthesopathy;
 - 4. Sympathetic reflex dystrophy;
 - 5. Subclacaneal bursitis; and
 - 6. Plantar fasciitis, as follows:
 - a. Synovitis;
 - b. Capsulitis;
 - c. Bursitis; or
 - d. Edema.
- (e) Services provided during a nursing home visit to cut, clean or trim toenails, corns, calluses or bunions of more than one resident shall be reimbursed at the nursing home single visit rate for only one of the residents seen on that day of service. All other claims for residents seen at the nursing home on the same day of service shall be reimbursed up to the multiple nursing home visit rate. The podiatrist shall identify on the claim form the single resident for whom the nursing home single visit rate is applicable, and the residents for whom the multiple nursing home visit rate is applicable.
- (f) Debridement of mycotic conditions and mycotic nails is a covered service provided that utilization guidelines established by the department are followed.
- (3) NON-COVERED SERVICES. The following are not covered services:
 - (a) Procedures which do not relate to the diagnosis or treatment of the ankle or foot;
 - (b) Palliative or maintenance care, except under sub. (2);
 - (c) All orthopedic and orthotic services except plaster and other material cast procedures and strapping or tape casting for treating fractures, dislocations, sprains or open wounds of the ankle, foot or toes;
 - (d) Orthopedic shoes and supportive devices such as arch supports, shoe inlays and pads;
 - (e) Physical medicine exceeding the limits specified under sub. (2) (d);
 - (f) Repairs made to orthopedic and orthotic appliances;
 - (g) Dispensing and repairing corrective shoes;

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- (h) Services directed toward the care and correction of "flat feet;"
- (i) Treatment of subluxation of the foot; and
- (j) All other services not specifically identified as covered in this section.

History: Emerg. cr. eff. 7-1-90; cr. Register, January, 1991, No. 421, eff. 2-1-91.

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WYOMING (From: *Wyoming Equality Care FAQs; Equality Care Wyoming Medicaid Handbook; Chapter 6 of Wyoming Medicaid Rules: HEALTH CHECK (formerly EPSDT) PROGRAM CHAPTER 6; Medicaid.gov: Early Periodic Screening Diagnosis & Treatment; 42 U.S.C. 1396d(r)*) (r)

6. Does Wyoming EqualityCare enroll podiatrists, chiropractors, and psychologists?

Yes, for Medicare crossovers only.

What are the limits and restrictions to the EqualityCare Programs?

If you are unsure about current benefits, discuss it with your healthcare provider before receiving services. If EqualityCare does not cover a service, you will be responsible for payment.

The following services are NOT covered:

- Podiatrist services, except where Medicare is the primary insurance

Other Necessary Health Care Services

States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

(r) Early and periodic screening, diagnostic, and treatment services

The term “early and periodic screening, diagnostic, and treatment services” means the following items and services:

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

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***There is no explicit language from Wyoming on whether Podiatry is covered under EPSDT (Health Check in Wyoming) beyond language discussing medically necessary actions.**

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