Section 2

Podiatric Services

Table of Contents

1 General Information ... 2
1-1 General Policy ... 2
1-2 Fee-For-Service or Managed Care ... 2
1-3 Definitions ... 3
2 Provider Participation Requirements ... 3
2-1 Provider Enrollment ... 3
3 Member Eligibility ... 3
4 Program Coverage ... 3
4-1 Covered Services ... 3
5 Non-Covered Services and Limitations ... 4
5-1 Non-Covered Services ... 4
5-2 Limitations ... 5
6 Billing ... 6
6-1 Prior Authorization ... 6
7 References ... 6
INDEX ... 7

1 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*) and the *Physician Services Utah Medicaid Provider Manual*.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

Practice of Podiatry

The "practice of podiatry" means the examination, diagnosis, or treatment medically, mechanically, or surgically of the ailments of the human foot. In accordance with Utah Code Annotated 58-5a--5-102, the practice of podiatry is limited to the human foot and ankle with some restrictions.

1-1 General Policy

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. Podiatric service may be provided to a Medicaid recipient who has a foot problem that causes:

- Difficulty walking or inability to walk
- Painful or distressing impairment which limits independent function
- Crippling

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. A Medicaid member enrolled in an MCP (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called “carve-out services,” which may be billed directly to Medicaid. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid Member Services hotline at (844) 238-3091 for further information..

Refer to the provider manual, *Section I: General Information,* for information regarding MCPs.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member’s enrollment in a managed care plan. However, it is the provider’s responsibility to verify eligibility and plan enrollment for a

member before providing services. *Therefore, if a Medicaid member is enrolled in an MCP, a fee-for-service claim will not be paid unless the claim is for a "carve-out service."*

Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility
- AccessNow: (800) 662-9651
- Member Services hotline at (844) 238-3091

1-3 Definitions

Definitions of terms used in Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*).

2 Provider Participation Requirements

2-1 Provider Enrollment

Refer to provider manual, *Section I: General Information* for provider enrollment information.

3 Member Eligibility

Confirmation of member eligibility is required prior to each service or at least once per month. The member must present their Medicaid Member Card, and the provider must verify the member's eligibility before services are rendered. To verify eligibility, contact AccessNow at (800) 662-9651 or on-line at the Medicaid web site Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility. For more information regarding verifying eligibility, refer to provider manual, Section I: General Information, Verifying Medicaid Eligibility.

4 Program Coverage

Procedure Codes

With some exceptions, procedure codes with accompanying criteria and limitations were removed from the manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

4-1 Covered Services

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

Podiatric services include the following:

- Foot incision

- Foot excision
- Repair, revision or reconstruction
- Nail treatment for mycotic toenails, corns, warts or calluses when the patient has a diagnosis of diabetes, arteriosclerosis or Buerger's disease (subject to limitations see Chapter 5).
- Radiology
- 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.
- Medical supplies and materials used by the podiatrist over and above those usually included for the surgical procedure.

Shoes and Shoe Repair

- Shoes are a Medicaid benefit only when the shoe is:
  - Attached to a brace or prosthesis or
  - Specially constructed to provide for a totally or partially missing foot.
    - For coverage, documentation is required of a
      - Previous amputation and/or
      - Diagnosis of diabetes with previous foot ulcerations
- 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 buildup of one inch or more.

5 Non-Covered Services and Limitations

For additional non-covered services or limitations, refer to the Coverage and Reimbursement Lookup Tool at the Medicaid website at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

5-1 Non-Covered Services

The following services are not covered:

- Preventive maintenance or routine foot care ordinarily within the realm of self-care, nursing home care, or long-term facility care is not a benefit. This includes:
  - The removal of corns, warts or calluses unless a danger to the patient exists (for example: diabetes, arteriosclerosis or Buerger's disease).
  - The trimming, cutting, clipping, or debriding of nails.
  - 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 of bedfast patients, and any other service performed in the absence of localized illness or injury.
  - Any application of topical medication or any treatment of fungal (mycotic) infection of the toenail, except when there is limitation to ambulation or pain.

- Supportive devices including arch supports, orthotics, or metatarsal head appliances are not a benefit.
- Treatment and evaluations of subluxation or flat feet is not a benefit.
    - 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 that require treatment only by nonsurgical methods regardless of underlying pathology.
    - The treatment, including evaluations and the prescriptions of supporting devices, of the local condition of flattened arches regardless of the underlying pathology.
- 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 buildup of one inch or more.
- Internal modification of a shoe is not a benefit.
- Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.
- Special shoes such as:
    - Mismatched shoes (unless attached to a brace);
    - Shoes to support an overweight individual;
    - Trade name or brand name shoes considered "orthopedic" or "corrective";
    - "Athletic" or "walking" shoes.
- Arch supports, foot pads, metatarsal head appliances or foot supports.
- 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.
- The manufacture, dispensing, or services related to orthotics of the feet.

5-2 Limitations

- Limitations that apply to services provided by a physician or osteopath also apply to services provided by a podiatrist.
- Surgical procedures on Medicaid recipients who reside in a nursing home are subject to post payment review. Recovery of payment will be made if the service was not appropriate.
- 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.
- A person licensed to practice podiatry may not administer general anesthesia and may not amputate the foot.
- Palliative care must include the specific service and must be billed by the specific service and not by using an evaluation and management (E&M) (office call) procedure code.
- Medicaid members residing in a nursing home or long-term care facility may receive benefits from the podiatry program as indicated in covered services with the following limitations.
    - Payment for nursing home E&M visits is not a benefit. Only services performed can be billed.
    - These services are limited to once every 60 days and are subject to post-payment review:
        - Foot care
        - Debridement of mycotic toenails
        - Trimming corns, warts, calluses, or nails. (Services are only available to patients with diabetes, arteriosclerosis, or Buerger's disease.)

6 Billing

For detailed billing instructions and general information about the co-payment requirement, members required to make a co-pay, exempt members, refer to *Section I: General Information,* Medicaid Copayments.

Co-payment

With some exceptions, Medicaid members are required to make a $3.00 co-payment for office visits performed by a podiatrist. The co- payment may be required for MCP and fee-for-service members as well as for services performed in a Federally Qualified Health Center (FQHC). The provider is responsible for determining which members are responsible for a co- payment and to collect the co-payment at the time of service or bill the member. Medicaid automatically deducts the amount of the co-payment from the claim reimbursement.

Pregnant women are exempt from the co- payment requirement. If the system does not indicate the patient is pregnant, add pregnancy diagnosis V22.2 to the claim.

To determine if a co-pay is required, contact AccessNow at (800) 662-9651.

Palliative care coding

Bill palliative care for the specific service code and not by an office call or E&M code.

6-1 Prior Authorization

Some services, particularly surgical services, require the podiatrist to obtain prior authorization (PA) from Medicaid before service. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retroactively eligible for the dates of service requested.

Additional prior authorization information is in the provider manual, *Section I: General Information.* Code specific coverage and prior authorization requirements are on the Medicaid website, Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

7 References

State Plan Amendment, Attachment 3.1-A, Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

Code of Federal Regulations, Medical or other remedial care provided by licensed practitioners, title 42, sec. 440.60

Index

AccessNow 3, 6

arch supports 5

arteriosclerosis 4, 5

Buerger's disease 4, 5

Co-payment 6

Coverage and Reimbursement Lookup Tool 3, 6

diabetes 4, 5

Eligibility Lookup Tool 3

EPSDT 2

EPSDT Services are mandatory 2

long-term care facility 4, 5

Nail

  clipping 4

  cutting 4

  debriding 4

  mycotic 4

  trimming 4

Optional services 2

orthotics 5

Palliative care 6

Physician Services Utah Medicaid Provider Manual 2

Practice of Podiatry 2

Prior authorization

  surgical services 6

Procedure Codes 3

Removal of

  calluses 4

  corns 4

  warts 4

removal of corns 4

routine foot care 4

Section I: General Information 2, 3

  Managed Care Plan (MCP) 2

Shoe Repair 4

Shoes 4

subluxation 5

Surgical correction

  subluxated foot 4

  to improve function 4