CHAPTER 19-000 PODIATRY SERVICES

19-001 Definitions

Mid-Calf: 50% of the total distance between the talus and tibial plateau.

Podiatry: The diagnosis or medical, physical, or surgical treatment of the ailments of the human foot, ankle, and related governing structures except (1) the amputation of the forefoot, (2) the general medical treatment of any systemic disease causing manifestations in the foot, and (3) the administration of anesthetics other than local.

Soft Tissue Wound: Lesion to the musculoskeletal junction that includes dermal and sub-dermal tissue that does not involve bone removal or repair or muscle transfer.

19-002 Provider Requirements

19-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of podiatry services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that provider participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in 471 NAC Chapter 19, the individual provider participation requirements in 471 NAC Chapter 19 shall govern.

19-002.02 Service Specific Provider Requirements: Podiatrists must be licensed by the Nebraska Department of Health and Human Services, Division of Public Health. If podiatry services are provided outside Nebraska, the podiatrist must be licensed in that state.

19-002.02A Provider Agreement: The podiatrist shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

19-003 Service Requirements

19-003.01 General Requirements

19-003.01A Medical Necessity: Podiatry services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

19-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

19-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

19-003.02 Covered Services: Medicaid covers medically necessary podiatry services within the scope of the podiatrist's licensure and within program guidelines (471 NAC 19-003.02).

19-003.02A Routine Foot Care: Routine foot care includes:

i. Cutting or removal of corns or calluses;
ii. Trimming of nails;
iii. 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; and,
iv. Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

19-003.02A1 Frequency Limitations: Coverage of routine foot care is limited to:

a. One treatment every 90 days for non-ambulatory clients; or,
b. One treatment every 30 days for ambulatory clients.

19-003.02A2 Evaluation and Management (E&M) Services: E&M services are not covered in addition to routine foot care (such as debridement or reduction of nails, corns, and calluses, etc.) on the same date of service, except:

a. New patient visits; or
b. When another separately identifiable service or procedure provided on the same date is documented in the medical record.

19-003.02B Surgery: Surgical procedures performed by podiatrists must be in accordance with the provisions of Neb. Rev. Stat. §38-3011.

19-003.02B1 Site of Service Limitation: Medicaid accepts Medicare's determination of surgical procedures that are primarily performed in office settings.

19-003.02B2 Sterile Surgical Trays: Medicaid covers one sterile surgical tray for each surgical procedure the podiatrist performs on a Medicaid client, in his/her office.

19-003.02B3 Assistant Surgery: Medicaid covers an assistant surgeon only for surgical procedures that are identified by CMS/AMA HCPCS coding as warranting an assistant surgeon.

19-003.02C Supportive Devices for the Feet: Medicaid covers orthopedic footwear, shoe corrections, orthotic devices and similar supportive devices for the feet if medically necessary for the client's condition. In addition to coverage as outlined herein, please see 471 NAC 7-013.

19-003.02D Clinical Laboratory Services: Medicaid covers clinical laboratory services that are:

1. Medically Necessary;
2. Provided in a podiatrist's, or group of podiatrists', private office; and,
3. Provided or supervised by the podiatrist(s).

19-003.02E Injections: Medicaid covers intramuscular and subcutaneous injections at the cost of the medication plus an injection fee.

19-003.02F Supplies: Medicaid may cover medically necessary supplies that are used during the course of treatment and require application by the podiatrist (e.g., splints, casts and other devices used in the treatment of fractures, etc.). Routine supplies, and supplies that are considered incidental to the professional service (e.g., application of surgical dressings) are not covered.

19-004 Billing and Payment for Podiatry Services

19-004.01 Billing

19-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in 471 NAC Chapter 19, the billing requirements in 471 NAC Chapter 19 shall govern.

19-004.01B Specific Billing Requirements

19-004.01B1 Billing Instructions: Providers shall bill Medicaid, using the appropriate claim form or electronic format (see Claim Submission Table at Appendix 471-000-49), and in accordance with the billing instructions included in Appendix 471-000-63.

19-004.02 Payment

19-004.02A General Payment Requirements: Medicaid will reimburse provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 19, the payment regulations in 471 NAC Chapter 19 shall govern.

19-004.02B Specific Payment Requirements

19-004.02B1 Reimbursement: Medicaid pays for covered podiatry services in an amount equal to the lesser of:

a. The provider's submitted charge; and
b. The allowable amount for that procedure code in the Medicaid Practitioner Fee Schedule (471-000-519) in effect for that date of service.

19-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471-000-70.

19-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

19-004.02B4 Payment for Surgery: Payment for surgeries is as follows:

a. Surgical procedures are arranged in descending order according to Medicaid's allowable charges. The major procedure is paid at 100 percent of the allowable charge; and
b. Subsequent procedures are paid at 50 percent of the allowable charge.

Except for the initial office visit, payment for major surgical procedures includes office visits on the day of surgery and 14 days of post-operative care. Medicaid follows the surgery guidelines in the American Medical Association's Current Procedural Terminology (CPT).

Payment for surgical procedures that are primarily performed in office settings is reduced by 12% when performed in hospital outpatient settings (including emergency departments).

19-004.02B5 Sterile Surgical Trays: Payment for a sterile surgical tray includes surgical instruments (routine or special), office operating room cost, sutures, supplies, items used to prepare a sterile field for the surgical procedure, and the sterilization and maintenance of these items.

19-004.02B6 Supportive Devices for the Feet: Payment for custom orthotic devices which require impression casting by the podiatrist includes:
a. Fitting;
b. Cost of parts and labor;
c. Repairs due to normal wear and tear within 90 days of the date dispensed; and,
d. Adjustments made when fitting and for 90 days from the date dispensed.
   i. Adjustments necessitated by changes in the client's medical condition, or the client's functional abilities, are reimbursed separately.

19-002.04B7 Clinical Laboratory Services: Payment for specimens obtained in the podiatrist's office and sent to an independent clinical lab or hospital for processing must be claimed by the facility performing the tests. The Department does not reimburse the podiatrist for handling specimens or processing or interpreting tests performed outside the podiatrist's office.

CHAPTER 19-000 PODIATRY SERVICES

19-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), podiatrists must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If podiatry services are provided outside Nebraska, the podiatrist must be licensed in that state.

19-001.01 Provider Agreement: The podiatrist shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in NMAP.

19-002 Covered Services: NMAP covers medically necessary podiatry services within the scope of the podiatrist's licensure and within program guidelines.

19-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

19-002.01A Health Maintenance Organizations (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

19-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. In addition, services provided by a podiatrist require referral from the client's primary care physician (PCP). Providers shall contact the PCP before providing services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

19-003 Limitations and Requirements for Certain Services

19-003.01 Palliative Foot Care: Palliative foot care includes the cutting or removal of corns or calluses; 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 foot care is limited to: one treatment every 90 days for non-ambulatory clients and one treatment every 30 days for ambulatory clients.

Evaluation and management services are not covered in addition to palliative foot care on the same date of service, except:

1. New patient visits; or
2. Significant, separately identifiable evaluation and management services required to treat a condition above and beyond palliative foot care.

~~19-003.02 Surgery: When billing for surgical procedures, the provider shall use the appropriate procedure code modifier to identify the foot and digit on which the procedure was performed. When billing for multiple or bilateral surgeries, or reduced services or procedures, the podiatrist shall use the appropriate surgical procedure code.~~

~~19-003.02A Payment for Surgery: Payment for surgeries is as follows:~~

1. ~~Surgical procedures are arranged in descending order according to NMAP's allowable charges. The major procedure is paid at 100 percent of the allowable charge; and~~
2. ~~Subsequent procedures are paid at 50 percent of the allowable charge.~~

~~Except for the initial office visit, payment for major surgical procedures includes office visits on the day of surgery and 14-days' post-operative care. NMAP follows the surgery guidelines in the American Medical Association's Current Procedural Terminology (CPT).~~

~~19-003.02B Site of Service Limitation: Payment for surgical procedures that are primarily performed in office settings is reduced by 12% when performed in hospital outpatient settings (including emergency departments). NMAP accepts Medicare's determination of surgical procedures that are primarily performed in office settings.~~

~~19-003.02C Sterile Surgical Trays: NMAP covers sterile surgical trays for surgical procedures the podiatrist performs in his/her office. Payment is allowed for one sterile tray for each operative session for each client. Payment for a sterile surgical tray includes any and all surgical instruments (routine or special), office operating room cost, sutures, supplies, any and all items used to prepare a sterile field for the surgical procedure, and the sterilization and maintenance of these items. The podiatrist shall bill NMAP for the sterile surgical tray on the same claim as the surgical procedure.~~

~~19-003.02D Assistant Surgery: NMAP covers an assistant surgeon only for surgical procedures that warrant an assistant surgeon.~~

~~19-003.03 Supportive Devices for the Feet: NMAP covers orthopedic footwear, shoe corrections, orthotic devices and similar supportive devices for the feet if medically necessary for the client's condition.~~

~~Payment for custom orthotic devices which require impression casting by the podiatrist includes fitting, cost of parts and labor, repairs due to normal wear and tear within 90 days of the date dispensed, and adjustments made when fitting and for 90 days from the date dispensed when the adjustments are NOT necessitated by changes in the client's medical condition or the client's functional abilities.~~

~~19-003.04 Clinical Laboratory Services: If clinical laboratory services are provided in a podiatrist's or group of podiatrists' private office, payment may be claimed for the medically necessary laboratory services provided or supervised by the podiatrist(s).~~

~~Payment for specimens obtained in the podiatrist's office but sent to an independent clinical lab or hospital for processing must be claimed by the facility performing the tests. The Department does not reimburse the podiatrist for handling specimens or processing or interpreting tests performed outside his/her office.~~

~~19-003.05 Injections: NMAP reimburses intramuscular and subcutaneous injections at the cost of the medication plus an injection fee.~~

~~19-003.06 Supplies: NMAP will consider payment for certain supplies that are used during the course of treatment and require application by the podiatrist (e.g., splints, casts and other devices used in the treatment of fractures, etc.) except those supplies that are considered incident to the professional service (e.g., application of surgical dressings).~~

~~19-003.07 Mileage: NMAP may reimburse a podiatrist for mileage for home, nursing facility, or ICF/MR visits beyond a radius of ten miles from the point of origin (office or home). NMAP allows only one mileage charge per day for visits to a nursing facility or ICF/MR regardless of the number of clients treated. When billing for mileage, the podiatrist shall indicate the point of origin, the place where services were rendered, and the total number of miles traveled beyond ten miles from the point of origin on or with the claim.~~

~~19-003.08 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.~~

19-004 Payment for Podiatry Services: The Nebraska Medical Assistance Program (NMAP) pays for covered podiatry services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount;
   d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, 97.5 percent of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
   e. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

19-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

19-004.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.

19-004.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

19-005 Billing Requirements: Podiatrists shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The provider or the provider's authorized agent shall submit the provider's usual and customary charge for each procedure code listed on the claim.

19-005.01 Procedure Codes for Podiatry Services: Podiatrists shall use the appropriate CPT or HCPCS procedure codes when billing NMAP.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-519).