TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 19 PODIATRY SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS.

002.01 PODIATRIST. A physician of the foot, ankle, and related governing structures.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Nebraska Medicaid, providers of podiatry services must comply with all applicable participation requirements codified in 471 Nebraska Administrative Code (NAC) 1, 2 and 3. In the event that provider participation requirements in 471 NAC 1, 2 or 3 conflict with requirements outlined in 471 NAC 19, the individual provider participation requirements in 471 NAC 19 will govern.

003.02 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.

003.03(A) PROVIDER AGREEMENT. The podiatrist will complete and sign a Medical Assistance Provider Agreement, and submit the completed form to the Department for approval to participate in Nebraska Medicaid.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. Nebraska Medicaid incorporates the definition of medical necessity from 471 NAC 1. Services and supplies that do not meet the 471 NAC 1 definition of medical necessity are not covered.

004.01(B) SERVICES PROVIDED FOR RECIPIENTS ENROLLED IN THE NEBRASKA MEDICAID MANAGED CARE PROGRAM. See 471 NAC 1.

004.01(C) EARLY AND PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES. See 471 NAC 33.

004.02 COVERED SERVICES. Nebraska Medicaid covers medically necessary podiatry services within the scope of the podiatrist's licensure and within program guidelines.

004.02(A) ROUTINE FOOT CARE. Routine foot care includes:

(1) Cutting or removal of corns or calluses;
(2) Trimming of nails;
(3) Other hygienic and preventive maintenance care or debridement; and
(4) Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

004.02(A)(i) FREQUENCY LIMITATIONS. Coverage of routine foot care is limited to:

(a) One treatment every 90 days for non-ambulatory recipients; or
(b) One treatment every 30 days for ambulatory recipients.

004.02(A)(ii) EVALUATION AND MANAGEMENT (E&M) SERVICES. (E&M) services are not covered in addition to routine foot care 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.

004.02(B) SURGERY. Surgical procedures performed by podiatrists must be in accordance with the provisions of Neb. Rev. Stat. § 38-3011.

004.02(B)(i) SITE OF SERVICE LIMITATIONS. Nebraska Medicaid accepts Medicare's determination of surgical procedures that are primarily performed in office settings.

004.02(B)(ii) STERILE SURGICAL TRAYS. Nebraska Medicaid covers one sterile surgical tray for each surgical procedure the podiatrist performs on an individual, in their office.

004.02(B)(iii) ASSISTANT SURGERY. Nebraska Medicaid covers an assistant surgeon only for surgical procedures that are identified as warranting an assistant surgeon.

004.02(C) SUPPORTIVE DEVICES OF THE FEET. Nebraska Medicaid covers orthopedic footwear, shoe corrections, orthotic devices and similar supportive devices for the feet if medically necessary for the recipient's condition. In addition to coverage as outlined herein, please see 471 NAC 7.

004.02(D) CLINICAL LABORATORY SERVICES. Nebraska Medicaid covers clinical laboratory services that are:

(i) Medically necessary;
(ii) Provided in a podiatrist's, or group of podiatrists', private office; and
(iii) Provided or supervised by the podiatrist(s).

004.02(E) INJECTIONS. Nebraska Medicaid covers intramuscular and subcutaneous injections at the cost of the medication plus an injection fee.

004.02(F) SUPPLIES. Nebraska Medicaid may cover medically necessary supplies that are used during the course of treatment and require application by the podiatrist. Routine supplies, and supplies that are considered incidental to the professional service are not covered.

005. BILLING AND PAYMENT FOR SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 3. In the event that billing requirements in 471 NAC 3 conflict with billing requirements outlined in 471 NAC 19, the billing requirements in 471 NAC 19 will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) BILLING INSTRUCTIONS. Providers must bill Nebraska Medicaid using the appropriate claim form or electronic format.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. The department will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that payment regulations in 471 NAC 3 conflict with payment regulations outlined in 471 NAC 19, the payment regulations in 471 NAC 19 will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS.

005.02(B)(i) REIMBURSEMENT. Nebraska Medicaid pays for covered podiatry services in an amount equal to the lesser of:

(1) The provider's submitted charge; and
(2) The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service.

005.02(B)(ii) MEDICARE AND NEBRASKA MEDICAID CROSSOVER CLAIMS. For information on the payment of Medicare and Nebraska Medicaid crossover claims, see 471 NAC 3.

005.02(B)(iii) COPAYMENT. For Nebraska Medicaid copayment requirements, see 471 NAC 3.

005.02(B)(iv) PAYMENT FOR SURGERY. Payment for surgeries is as follows:

(1) Surgical procedures are arranged in descending order according to the Department'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.
(3) 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. The department follows the surgery guidelines in the American Medical Association's Current Procedural Terminology (CPT).
(4) Payment for surgical procedures that are primarily performed in office settings is reduced by 12 percent when performed in hospital outpatient settings, including emergency departments.

005.02(B)(v) STERILE SURGICAL TRAYS. Payment for a sterile surgical tray includes routine or special surgical instruments, 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.

005.02(B)(vi) SUPPORTIVE DEVICES FOR THE FEET. Payment for custom orthotic devices which require impression casting by the podiatrist includes:
(1) Fitting;
(2) Cost of parts and labor;
(3) Repairs due to normal wear and tear within 90 days of the date dispensed; and
(4) Adjustments made when fitting and for 90 days from the date dispensed; and
(a) Adjustments necessitated by changes in the recipient's medical condition, or the recipient's functional abilities, are reimbursed separately.

005.02(B)(vii) 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.