Iowa Department of Human Services

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PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 18-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: ***Podiatric Services Manual***, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; and pages 2 through 7, revised.

Summary

The ***Podiatric Services Manual*** is revised to align with current policies, procedures, and terminology.

Effective Date

Immediately.

Material Superseded

This material replaces the following pages from the ***Podiatric Services Manual***:

Page	Date
Chapter III	
Contents (page 1)	January 1, 2016
2	June 1, 2017
3, 4	January 1, 2016
5	June 1, 2017
6	May 1, 2014
7, 8	June 1, 2017
9, 10	January 1, 2016
11	June 1, 2017

Additional Information

The updated provider manual containing the revised pages can be found at:
http://dhs.iowa.gov/sites/default/files/Podia.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

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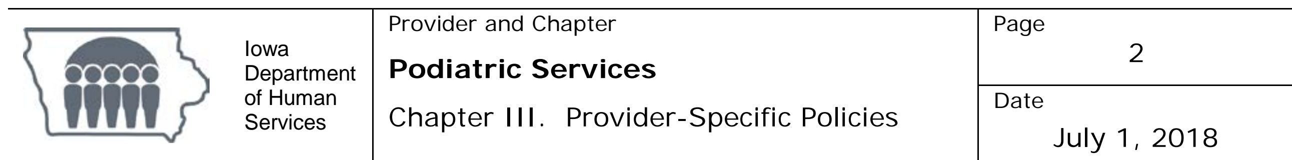

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

2. Orthopedic Shoes

Payment will be made for the examination to establish the need for orthopedic shoes, including required tests. On all claims containing a charge for such service, indicate the date the shoes were prescribed, the diagnosis, and the reason orthopedic shoes are needed.

Payment may be made to a doctor of podiatry for orthopedic shoes.

Payment will be made to orthopedic shoe dealers for orthopedic shoes prescribed in writing by a doctor of podiatry. A prescription for custom-made shoes must include the diagnosis. The shoe dealer has been directed to return the prescription for custom-made shoes to the prescriber when the diagnosis has been omitted. For more information, click here for the Orthopedic Shoe Dealer Manual.

3. Orthotic Appliances

In addition to Medicare-covered services, payment will be approved for certain orthotic appliances, as follows:

- Durable plantar foot orthotic
- Plaster impressions for foot orthotic
- Molded digital orthotic
- Shoe padding (when appliances are not practical, e.g., for a young, rapidly growing child, but not limited to children)
- Custom-made shoes (only for severe rheumatoid arthritis, congenital defects and deformities, neurotrophic, diabetic and ischemic intractable ulcerations and deformities due to injuries), includes impression

No payment will be made for the dispensing of two pair of orthotic appliances at the same time.

4. Radiological and Pathological Services

Payment will be made for x-ray and laboratory tests which are reasonable and necessary for the diagnosis or treatment of a member's podiatric condition and are not being rendered in connection with excluded services.

5. Routine Foot Care

Routine foot care includes the cutting or removal of corns or calluses, the trimming of 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 members, and any services performed in the absence of localized illness, injury or symptoms involving the foot.

<u>Routine foot care is not a covered service</u>. Foot care such as routine soaking and application of topical medication on a physician's order between required visits to the physician is not covered. **NOTE:** Payment **will** be made for removal of warts.

The nonprofessional performance of certain foot care procedures otherwise considered routine, such as cutting or removal of corns, calluses or nails, can present a hazard to people with certain diseases. If a procedure does present a hazard to the member, it is not considered routine when the member is under the care of a doctor of medicine or osteopathy.

The requirement for coverage of routine foot care is that a member must have one of the following diagnoses:

- ♦ Arteriosclerosis obliterans (A.S.O. arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- ♦ Buerger's disease
- ♦ Chronic thrombophlebitis *
- ♦ Diabetes mellitus *
- ♦ Peripheral neuropathies involving the feet associated with: *
  - Alcoholism
  - Drugs and toxins
  - General and pellagra malnutrition
  - Leprosy or neurosyphilis
  - Malabsorption (celiac disease, tropical sprue)
  - Malignancy of the tissues of the foot
  - Multiple sclerosis
  - Pernicious anemia
  - Traumatic injury
  - Uremia
- ♦ Hereditary disorders:
  - Angiokeratoma corporis diffusum (Fabry's)
  - Amyloid neuropathy
  - Hereditary sensory radicular neuropathy

* If the diagnosis is followed by an asterisk (*), the claim must also include the following:

- ♦ The name of the attending physician, either an M.D. or D.O.
- ♦ The date of the member's last visit to the attending physician within the last six months or the date of a planned future visit within one month.

6. Treatment of Nail Pathologies

In addition to Medicare-covered services, payment will be approved for certain treatment of nail pathologies, as follows:

- Excision of nail and nail matrix, partial or complete for permanent removal
- Excision of nail simple (i.e., ingrown or deformed) without permanent removal
- Debridement of nails for:
  - Persons under active treatment by a physician (MD or DO) for certain diseases
  - Rams horn (hypertrophied) nails
  - Onychomycosis (mycotic) nails

7. Treatment of Pes Planus

Acquired pes planus is defined as a condition in which one or more arches have flattened out. Services directed toward the care or correction of pes planus are not covered, except when treated by orthotic appliances (see Orthotic Appliances), or by orthopedic shoes (see Orthopedic Shoes).

8. Treatment of Subluxations of the Foot

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered. (**EXCEPTION:** See Orthopedic Shoes.)

Reasonable and necessary diagnosis and treatment of symptomatic conditions, such as osteoarthritis, bursitis (including bunion), tendinitis, etc., that result from or are associated with partial displacement of foot structures are covered services.

Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury is a covered service when it is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

9. Injected Medication

a. Covered Services

Payment will be approved for injections, provided they are reasonable, necessary, and related to the diagnosis and treatment of a podiatric-related illness or injury. The following information must be provided when billing for injections:

- HCPCS Level II procedure code
- NDC
- Units of service
- Charge for each injection

When the above information is not provided, claims potentially will be denied.

b. Non-Covered or Limited Services

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions are applicable:

- **Injections not indicated for treatment of a particular condition**. Payment will not be approved for injections when they are considered by standards of podiatric licensure and scope of practice to not to be specific or effective treatment for the particular podiatric condition for which they are administered.
- **Injections not for a particular illness**. Payment will not be approved for an injection if administered for a reason other than the treatment of a particular podiatric condition, illness or injury.
- **Method of injection not indicated**. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of podiatric practice.
- **Excessive injections**. Basic standards of podiatric practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

10. Prescription Drugs

Payment will be made for drugs and devices used for podiatric purposes and requiring a prescription by law. For additional information, click here to view the Prescribed Drugs manual.

D. BASIS OF PAYMENT

The basis of payment for services is a fee schedule. The fee schedule amount is a maximum payment amount, not an automatic payment. Reimbursement will be the lower of the customary charge or the fee schedule amount.

Click here to view the Podiatric Services fee schedule online.

The charges for services provided to Medicaid members must not exceed the customary charges to private pay patients.

E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered.

It is the provider's responsibility to select the procedure code that best describes the item dispensed. A claim submitted without a procedure code and a corresponding diagnosis code will be denied.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Podiatric Services are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click here to view a sample of the CMS-1500.

Click here to view billing instructions for the CMS-1500.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.