



Iowa Department of Human Services

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For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

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PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **PODIATRIC SERVICES MANUAL**, Title page, revised; Table of Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Title page, new; Table of Contents (page 1), new; and pages 1 and 11, new.

Summary

The **PODIATRIC SERVICES MANUAL** is revised to:

- ◆ Reformat and revise the chapters on coverage and limitations and billing and payment to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters. This includes:
 - Removing Chapter E. Information on coverage and limitations is now included in Chapter III. *Provider-Specific Policies*.
 - Removing Chapter F. Billing and payment information and forms are now included in Chapter IV. *Billing Iowa Medicaid*.
- ◆ Align with current policies, procedures, and terminology.
- ◆ Ensure that current contact information is provided.
- ◆ Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make sure that the most recent version of the form is accessible.

Date Effective

Upon receipt.

Material Superseded

This material replaces the entire Chapter E and Chapter F from the ***PODIATRIC SERVICES MANUAL***, which includes the following:

| <u>Page</u> | <u>Date</u> |
|------------------------|------------------|
| Title page | Undated |
| Contents (page 4) | January 1, 1994 |
| Contents (page 5) | December 1, 1998 |
| Chapter E | |
| 1-26 | January 1, 1994 |
| Chapter F | |
| 1-8 | December 1, 1998 |
| 9, 10 (HCFA-1500) | 12/90 |
| 11, 12 | December 1, 1998 |
| 13 (Remittance Advice) | 6/12/97 |
| 15-17 | December 1, 1998 |
| 21 (470-0040) | 10/02 |

Additional Information

The updated provider manual containing the revised pages can be found at:
http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/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.

Podiatric Services Provider Manual



**Iowa Department
of Human Services**

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS FOR PARTICIPATION

All doctors of podiatry licensed to practice in the state of Iowa are eligible to participate in the Medicaid program. Doctors of podiatry in other states are also eligible to participate providing they are duly licensed in that state.

B. COVERAGE OF SERVICES

Payment will be made for the same scope of podiatric services available through Part B of Medicare, except as outlined below.

1. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services
- ◆ Interpreters may be employed or contracted by the billing provider
- ◆ The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ Cost of providing the service.



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 will not 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.



Payment will also be made to the shoe repair shop for modifications of orthopedic shoes (padding, wedging, metatarsal bars, built-up soles or heels, etc.) prescribed in writing by a doctor of podiatry.

No payment will be approved for two pairs of shoes purchased at the same time, except when the second pair is:

- ◆ Tennis shoes needed to meet educational requirements, or
- ◆ Shoes prescribed for a medically related reason; e.g., to attach night braces.

The reason for the exception must be written on the prescription.

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 condition and are not 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.

Routine foot care is not a covered service. 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
 - Arcinoma
 - Drugs and toxins
 - General and pellagra malnutrition
 - Leprosy or neurosyphilis
 - Malabsorption (celiac disease, tropical sprue)
 - 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 O.D.
- ◆ 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

See [PROCEDURE CODES AND NOMENCLATURE](#) for these services.

7. Treatment of Pes Planus

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.

C. PAYMENT OF PRESCRIPTION DRUGS AND MEDICAL SUPPLIES

Payment will be made only for legend drugs and a limited number of non-legend drugs prescribed by a doctor of podiatry. (Payment will not be made for drugs classified as less than effective by the Food and Drug Administration.)

A written prescription is required for all supplies. Place the provider number on the prescription. A new prescription for shoes and supplies is required on each occasion.

Payments will be made for drugs dispensed by a podiatrist only when the podiatrist's office is located in a community that has no licensed retail pharmacy. If the provider is eligible to dispense drugs by this policy, request a copy of the Prescribed Drugs Manual from the Iowa Medicaid Enterprise (IME).

Payment will not be made for writing prescriptions.



1. Cost and Quantity Standards

NOTE: Only retain the requirements below if it is determined that there are any "J," "Q," or "S" code drugs that are covered and payable for podiatrists, and which would otherwise require PA.

The provider shall cooperate with the Department in keeping the cost of drugs to a minimum, consistent with a good quality of patient care.

When a medication is available at several price levels, prescribe low-cost items whenever possible. In writing prescriptions, prescribe a 30-day supply, unless therapeutically contraindicated.

While additional reimbursement is not provided for unit-dose packaged medication, such medication may be used for Medicaid members, particularly those in nursing care facilities.

Payment for drug products which have lower-cost equivalents available is limited to the average wholesale price of the equivalent product dispensed. "Equivalent products" are defined as those products which meet therapeutic equivalence standards as published in the U.S. Food and Drug Administration document, "Approval Prescription Drug Products with Therapeutic Equivalence Evaluations."

If a lower-cost equivalent product is not dispensed in place of a more expensive brand-name product, the maximum allowable reimbursable cost is 150 percent of the average wholesale price of the least costly equivalent product.

Procedures for exceptions to the maximum allowable cost are the same as those in effect for the Federal Maximum Allowable Cost Program, i.e., certification in the prescriber's own handwriting that in the prescriber's medical judgment a specific brand is medically necessary.



2. Injected Medication

a. Covered Services

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

- ◆ HCPCS code
- ◆ NDC
- ◆ Units of service
- ◆ Charge for each injection

When the above information is not provided, claims potentially will be denied. To the extent a podiatrist would be part of a 340B program, proper billing is as per instruction in IL 699. The provider should include the NDC for the drug if billing under the 340B program where the UD modifier is appended. While this isn't required per IL 699, this is necessary information to price the drug, especially if billed under an unlisted HCPCS code.

b. Non-Covered or Limited Services

For injections related to diagnosis or treatment of illness or injury, 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 medical practice not to be specific or effective treatment for the particular condition for which they are administered. The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.
- ◆ **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 condition, illness or injury.

NOTE: The provider shall obtain prior approval before employing an amphetamine or legend vitamin by injection. For additional information, click [here](#) to view the Prescribed Drugs manual.



- ◆ **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.
- ◆ **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the member for self-administration will be allowed according to coverage limits in effect for this service.
- ◆ **Excessive injections.** Basic standards of medical 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.

When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injection given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for the purpose of administering drugs, it will be disallowed along with the non-covered injections.

3. Legend Drugs and Devices

Payment will be made for drugs and devices requiring a prescription by law, with the following exceptions:

- ◆ Drugs not marketed by manufacturers that have a signed Medicaid rebate agreement
- ◆ Drugs prescribed for a use other than the drug's medically accepted use
- ◆ Drugs used to cause anorexia or weight gain
- ◆ Drugs used for cosmetic purposes or hair growth
- ◆ Drugs used to promote smoking cessation



- ◆ Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee
- ◆ Drugs classified as "less than effective" by the Food and Drug Administration

4. Non-Legend Drugs

Payment for non-legend drugs will be made in the same manner as for prescription drugs, except that a maximum allowable cost (MAC) is established at the median of the average wholesale prices of the chemically equivalent products available. No exceptions for reimbursement for higher cost products will be approved.

For additional information, click [here](#) to view the Prescribed Drugs manual.

Procedures for exceptions to the maximum allowable limit are the same as those in effect for the federal maximum allowable cost program, i.e., the doctor of podiatry certifies in the doctor's own handwriting that in the doctor's medical judgment a specific brand is medically necessary.

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.

Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

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.

The Billing Manual can be located online at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-iv.pdf.