



Iowa Department of Human Services

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PODIATRIC SERVICES MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **PODIATRIC SERVICES MANUAL**, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; and pages 3, 4, and 8 through 11, revised.

Summary

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

- ◆ Align with current IA Health Link policies, procedures, and terminology.
- ◆ Update links due to the Department's new website.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the **PODIATRIC SERVICES MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 1)	May 1, 2014
3, 4, 8-11	May 1, 2014

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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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 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.

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

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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 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. 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, 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 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.

When excessive injections appear, representing a departure from accepted standards of podiatric practice, the entire charge for injections given in excess of these standards will be excluded.

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 used for podiatric purposes and 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 for cosmetic purposes
- ◆ 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.

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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://dhs.iowa.gov/sites/default/files/All-IV.pdf>