



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Podiatry Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: December 15, 2016	Semiannual update: <ul style="list-style-type: none"> • Added managed care entity contact information in the Introduction section • Added policy and billing information to the Prior Authorization for Podiatry Services section • Added information regarding podiatry consultation services rendered in a nursing facility to the Coverage, Billing, and Reimbursement for Podiatry Services section • Added information regarding reimbursement for surgical services to the Surgical Services section • Added information about reimbursement for handling and conveyance of specimens to an outside laboratory in the Laboratory and X-Ray Services section • Clarified coverage limitations in the Doppler Evaluations section • Updated the prior authorization and reimbursement information in the Orthopedic or Therapeutic Footwear section 	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: February 23, 2017	<ul style="list-style-type: none"> • Added Portal billing instructions in the Routine Foot Care section • Revised audit description in the Office Visits section 	FSSA and HPE

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Note: For policy information regarding coverage of podiatry services, see the [Medical Policy Manual](#) at indianamedicaid.com.

Introduction

The Indiana Health Coverage Programs (IHCP) provides reimbursement for podiatry services, including the diagnosis of foot disorders and the mechanical, medical, or surgical treatment of these disorders, subject to the limitations, restrictions, and billing procedures described in this document.

Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at indianamedicaid.com.

Prior Authorization for Podiatry Services

Indiana Administrative Code 405 IAC 5-26 contains specific criteria pertaining to prior authorization (PA) for podiatry services, including PA guidelines for corrective features built into shoes, orthopedic shoes for members with severe diabetic foot disease, comparative foot x-rays, and surgical procedures performed within the scope of the podiatrist's license. Hospital stays, as outlined in *405 IAC 5-17*, require PA. The *IAC* should be used as the primary reference.

Any podiatrist services rendered during inpatient days that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed. Prior authorization is required for hospital stays as outlined in *405 IAC 5-21*.

Any podiatrist services rendered during an outpatient visit that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed.

In an emergency situation, for services requiring PA, the authorization must be obtained within 48 hours, not including Saturdays, Sundays, and legal holidays.

Coverage, Billing, and Reimbursement for Podiatry Services

The following sections describe coverage, requirements, billing procedures, and reimbursement policies for various types of podiatry services.

Note: Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on a routine basis for screening purposes, except in cases where a specific foot ailment is involved.

Routine Foot Care

Routine foot care includes the following:

- Cutting or removal of corns, calluses, or warts, including plantar warts
- Trimming of nails, including mycotic nails
- Treatment of fungal, mycotic infection of the toenail is routine foot care only when the following applies:
 - Clinical evidence of infection of the toenail is present.
 - Compelling medical evidence exists, documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, in the case of nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment.

For a list of Current Procedural Terminology (CPT^{®1}) and Healthcare Common Procedure Coding System (HCPCS) codes for routine foot care, see *Podiatry Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

The IHCP covers routine foot care only if a medical doctor or doctor of osteopathy has seen the patient for treatment or evaluation of a systemic disease during the six-month period before rendering routine foot care services. Providers must include the name and NPI or Provider ID of the referring physician in the referring provider fields on the professional claim. Providers should also indicate the nature of the foot condition being treated by entering the appropriate diagnosis codes for the claim and including the appropriate diagnosis pointer for each service detail. See the [Claim Submission and Processing](#) module for complete claim form instructions. See the [Provider Healthcare Portal](#) module for online billing instructions.

The International Classification of Diseases (ICD) diagnosis codes for systemic conditions that justify coverage for routine foot care are listed in the *Podiatry Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

The IHCP covers a maximum of six routine foot-care services per rolling 12-month period when the patient has one of the following:

- A systemic disease of sufficient severity that treatment of the disease may pose a hazard when performed by a nonprofessional
- Severe circulatory impairment as a result of the systemic condition or areas of desensitization in the legs or feet

The IHCP does not cover routine foot-care services for Package C members.

Office Visits

IHCP reimbursement may be allowed for podiatric office visits, subject to the following restrictions:

- The IHCP allows for new patient office visits, using procedure codes 99201, 99202, and 99203, one per member, per provider, within the last three years, as defined by the CPT guidelines. (A “new patient” is defined as one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.)
- The IHCP limits reimbursement to one office visit, per member, per 12 months.

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Per 405 IAC 5-26-7, IHCP reimbursement is limited to one office visit per 12 months per member; additional visits may be billed only if a significant additional problem is addressed. Prior authorization does not allow claims to override audit 6090 – *Office visits limited to 1 per 12 months*. Instead, claims triggering this audit will suspend for medical review. During the medical review process, providers may be asked to submit documentation of medical necessity and proof of a significantly different diagnosis.

Note: The IHCP Program Integrity Department identified utilization issues related to podiatrists inappropriately billing multiple units of CPT codes 99201–99203 for new patient visits and CPT codes 99211–99213 for established patient visits.

All providers are advised to carefully review claims submitted to the IHCP to ensure proper billing of units for these services. The IHCP Program Integrity Department reviews claims to determine any inappropriate reimbursement and recoups overpayments. If a provider identifies overpayments related to these errors, the provider should file an adjustment or contact the IHCP Program Integrity Department to arrange for repayment.

Surgical Services

The IHCP may reimburse for the following podiatric surgical procedures without PA:

- Surgical cleansing of the skin
- Drainage of skin abscesses
- Drainage or injections of a joint or bursa
- Trimming of skin lesions

The IHCP allows reimbursement for surgical procedures other than those in the preceding list, performed within the scope of the podiatrist's license, subject to PA, as specified in 405 IAC 5-26. All covered surgical procedures on one foot or both feet performed on the same date will be paid up to 100% of the IHCP allowance for the major procedure and up to 50% of the IHCP allowance for subsequent procedures.

Second Opinions

The IHCP may require providers to obtain a second or third opinion substantiating the medical necessity of or approach to the following surgical procedures:

- Bunionectomy procedures
- All surgical procedures involving the foot

See 405 IAC 5-8 for information on consultations and second opinions.

Billing for Podiatric Surgical Procedures

For podiatric surgical procedures, including diagnostic surgical procedures, providers cannot fragment and bill separately. Generally, providers include such procedures in the major procedure. Procedures in this category include, but are not limited to, the following:

- Arthroscopy or arthrotomy procedures in the same area as a major joint procedure, unless the claim documents a second incision was made
- Local anesthesia administered to perform the surgical or diagnostic procedure
- Scope procedures used for the surgical procedure approach

Laboratory and X-Ray Services

The IHCP may allow a podiatrist to be reimbursed for laboratory or x-ray services only if the services are rendered by or under the personal supervision of the podiatrist. For services ordered by a podiatrist but performed by a laboratory or x-ray facility, the laboratory or x-ray facility bills the IHCP directly. The IHCP may reimburse the podiatrist for collection of a specimen sent to the laboratory. In addition, a podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory. The IHCP reimburses for the following lab and x-ray services billed by a podiatrist:

- Cultures for foot infections and mycotic fungal nails for diagnostic purposes
- Medically necessary presurgical testing
- Sensitivity studies for treatment of infection processes

The IHCP does not reimburse for comparative foot x-rays, unless prior authorized.

Doppler Evaluations

The IHCP provides coverage for ultrasonic measurement of blood flow (Doppler evaluation), subject to the following limitations:

- The ultrasonic measurement is for preoperative podiatric evaluation.
 - The measurement cannot be used for routine screening.
 - The measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.
- Prior authorization has been obtained for the proposed medical procedure.
- A preoperative diagnosis of diabetes mellitus, peripheral vascular disease, or peripheral neuropathy has been made.
- The preoperative Doppler evaluation is limited to one per year.

Orthopedic or Therapeutic Footwear

With a physician's written order, the IHCP provides reimbursement for members of all ages for the following:

- Corrective features built into shoes, such as heels, lifts, wedges, arch supports, and inserts
- Orthopedic footwear, such as shoes, boots, and sandals
- Orthopedic shoe additions

Prior authorization is required when a podiatrist prescribes or supplies corrective features built into shoes – such as heels, lifts, and wedges – for a member under 21 years of age.

If a member currently has a brace, the IHCP covers the shoes and supportive devices if a provider documents continued medical necessity.

Note: For all dually eligible members (receiving both Medicare and Medicaid), the IHCP provides reimbursement when a podiatrist renders orthotic services covered by Medicare.

The IHCP also provides coverage for therapeutic shoes for members with severe diabetic foot disease. Prior authorization is required when a podiatrist fits or supplies orthopedic shoes for members with severe diabetic foot disease, subject to the restrictions and limitations outlined in *405 IAC 5-19*. The HCPCS codes listed on the *Procedure Codes for Therapeutic Shoes for Severe Diabetic Foot Disease* table in the *Podiatry Services Codes* on the [Code Sets](#) page at indianamedicaid.com are the only codes that providers can use to bill for these services. Providers should not use these codes in any other circumstances.

The IHCP allows for one of the following:

- One pair of custom-molded shoes (A5501) and two additional pairs of inserts (A5512 or A5513)
- One pair of depth shoes (A5500) and three pairs of inserts (A5512 or A5513)
 - A5513 is limited to two inserts per date of service per rolling 12-month period

The member is eligible for a total of three pairs of inserts each calendar year. A5512 has a maximum unit of six per date of service. A5513 has a maximum unit of two per date of service. If the provider dispenses inserts independently of diabetic shoes, the member must have appropriate footwear into which to place the insert.

Providers should submit claims using the appropriate HCPCS codes with one unit of service for each code. If a member needs a *pair* of shoes and inserts, providers should submit claims using the appropriate HCPCS codes with “2” as the unit of service for each code.

The IHCP considers payment for the certification of the need for therapeutic shoes and the prescription of the shoes to be included in the office visit or consultation payment. Providers cannot bill for encounters for the sole purpose of dispensing or fitting shoes. The IHCP makes no payment for an office visit or consultation provided on the same day as the fitting or dispensing of shoes by the same physician.

The IHCP allows separate reimbursement of specific orthotic and prosthetic codes when rendered in the outpatient setting. See the [Durable and Home Medical Equipment and Supplies](#) module for more information.