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1.0 Description of the Procedure, Product, or Service

Podiatry, as defined by NCGS 90-202.2, “is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less.”

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a

condition” [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. ****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Recipients with Medicaid for Pregnant Women

Podiatry services for recipients with Medicaid for Pregnant Women (MPW) coverage are limited to medical conditions related to pregnancy or complications of pregnancy. Refer to **Subsection 5.1** for service requirements.

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

3.2 Specific Criteria

The services of a podiatrist are covered for specific diagnoses only. Refer to Attachment A Section B Diagnosis Codes for an approved list of diagnosis codes.

Note: Services of a podiatrist provided to a recipient on that recipient's first visit to the practice when billed with a new patient office visit code (99201-99205), will not deny for inappropriate diagnosis.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Routine foot care is not covered except as indicated in Clinical Coverage Policy #1C-2, *Medically Necessary Routine Foot Care*.

Curettement procedures or shaving of lesions are not covered except as indicated in Clinical Coverage Policy #1C-2, *Medically Necessary Routine Foot Care*.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

5.1 Prior Approval

Prior approval for podiatry services is not required, **except** for recipients with MPW coverage, to document medical necessity for services related to pregnancy or due to complications of pregnancy. Prior approval is obtained using the Medicaid Request for Prior Approval Form 372-118.

6.0 Providers Eligible to Bill for the Service

- a. The policy only applies to podiatrists.
- b. To be eligible to bill for procedures, products, and services related to this policy, providers shall
 1. meet Medicaid's qualifications for participation;
 2. be currently enrolled with N.C. Medicaid; and
 3. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: November 1, 1981

Revision Information:

Date	Section Revised	Change
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
12/01/10	Section 1.0	Added NCGS 90-202.2 and enclosed definition with quotations. Added standard DMA policy language
12/01/10	Section 2.0	Added EPSDT citation
12/01/10	Section 3.0	Added standard DMA policy language Added 3.1 General Criteria and 3.2 Specific Criteria: "The services of a podiatrist are covered for specific diagnoses only." "Refer to Attachment A Section B Diagnosis Codes for an approved list of diagnosis codes." Note: Services of a podiatrist provided to a recipient on that recipient's first visit to the practice when billed with a new patient office visit code (99201-99205), will not deny for inappropriate diagnosis."
12/01/10	Section 4.0	Added standard DMA policy language
12/01/10	Subsection 4.2	Removed Routine Foot Care and Added Specific Criteria.
12/01/10	Section 5.0	Added standard DMA policy language
12/01/10	Section 6.0	Added "a.The policy only applies to podiatrists." Added standard DMA policy language
12/01/10	Section 7.0	Added standard DMA policy language
12/01/10	Attachment A	Section A Claim Type Removed the statement Podiatrists, physicians, and nurse practitioners enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form. Added Professional (CMS-1500/837P transaction) and Institutional (UB-04-837I transaction).
12/01/10	Attachment A:	Section B: Added a list of approved diagnosis codes and descriptions
12/01/10	Attachment A:	Diagnosis Codes: Corrected descriptions of some codes
12/01/10	Attachment A:	Section E: Billing Units

Date	Section Revised	Change
12/01/10	Attachment A:	Section F: Added Inpatient, outpatient and office. Removed the place of service and description table. Section G: Updated co-payment and medical billing guide address. Added standard DMA policy language Section H: Reimbursement
06/01/11	Attachment A	(C) Adding spacing between sentences. Moved "Providers may bill one unit per date of service for the above procedure codes." Attachment A (E) to Attachment A (C)
06/01/11	Attachment A	(E) Added "The unit of service is determined by the appropriate procedure code(s) used."

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837 I transaction)

B. Diagnosis Codes

Providers must bill the appropriate ICD-9-CM diagnosis code that supports medical necessity. Diagnostic codes must be billed at their highest level of specificity.

Podiatrists' claims must contain one of the following diagnosis codes.

Code	Description
110.1	Dermatophytosis/Of nail
239.2	Neoplasms of unspecified nature/ Bone, soft tissue, and skin
249.80	Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
249.81	Secondary diabetes mellitus with other specified manifestations, uncontrolled
250.60	Diabetes with neurological manifestations / Type II or unspecified type, not stated as uncontrolled
250.61	Diabetes with neurological manifestations / Type I {juvenile type}, not stated as uncontrolled
250.62	Diabetes with neurological manifestations / Type II or unspecified type, uncontrolled
250.63	Diabetes with neurological manifestations / Type I {juvenile type}, uncontrolled
250.70	Diabetes with peripheral circulatory disorders / Type II or unspecified type, not stated as uncontrolled
250.71	Diabetes with peripheral circulatory disorders / Type I {juvenile type}, not stated as uncontrolled
250.72	Diabetes with peripheral circulatory disorders / Type II or unspecified type, uncontrolled
250.73	Diabetes with peripheral circulatory disorders / Type I {juvenile type}, uncontrolled
274.01	Acute gouty arthropathy
337.22	Reflex sympathetic dystrophy of the lower limb
355.5	Mononeuritis of lower limb / Tarsal tunnel syndrome
355.6	Mononeuritis of lower limb / Lesion of plantar nerve
356.1	Hereditary and idiopathic peripheral neuropathy / Peroneal muscular atrophy
356.8	Hereditary and idiopathic peripheral neuropathy / Other specified idiopathic peripheral neuropathy

357.2	Inflammatory and toxic neuropathy/Polyneuropathy in diabetes
440.23	Artherosclerosis of the extremities with ulceration
440.24	Artherosclerosis of the extremities with gangrene
443.0	Other peripheral vascular disease /Raynaud's syndrome
443.1	Other peripheral vascular disease / Thromboangiitis obliterans (Buerger's disease)
443.9	Peripheral vascular disease, unspecified
451.2	Phlebitis and thrombophlebitis / Of lower extremities, unspecified
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
454.0	Varicose veins of lower extremities / With ulcer
454.1	Varicose veins of lower extremities / With inflammation
454.2	Varicose veins of lower extremities / With ulcer and inflammation
457.1	Noninfectious disorders of lymphatic channels/Other lymphedema
681.10	Cellulitis and abscess, unspecified / Toe
681.11	Onychia and paronychia of toe
681.9	Cellulitis and abscess of unspecified digit
682.6	Other cellulitis and abscess / Leg, except foot
682.7	Other cellulitis and abscess / Foot, except toes
703.0	Diseases of nail / Ingrowing nail
707.07	Chronic ulcer of skin / Pressure ulcer / Heel
707.10	Ulcer of lower limbs, except pressure ulcer / Ulcer of lower limb unspecified
707.11	Ulcer of lower limbs, except pressure ulcer / Ulcer of thigh
707.12	Ulcer of lower limbs, except pressure ulcer / Ulcer of calf
707.13	Ulcer of lower limbs, except pressure ulcer / Ulcer of ankle
707.14	Ulcer of lower limbs, except pressure ulcer / Ulcer of heel and midfoot
707.15	Ulcer of lower limbs, except pressure ulcer / Ulcer of other part of foot
709.3	Degenerative skin disorders
713.5	Arthropathy associated with neurological disorders
714.0	Rheumatoid arthritis
718.47	Contracture of joint / Ankle and foot
726.71	Enthesopathy of ankle and tarsus / Achilles bursitis or tendinitis
726.72	Enthesopathy of ankle and tarsus / Tibialis tendinitis
726.79	Enthesopathy of ankle and tarsus / Other (peroneal tendinitis)
726.91	Unspecified enthesopathy / Exostosis of unspecified site
727.1	Other disorders of synovium, tendon, and bursa / Bunion
727.67	Rupture of tendon, nontraumatic / Achilles tendon
727.68	Rupture of tendon, nontraumatic / Other tendons of foot and ankle
728.71	Plantar fascial fibromatosis
728.86	Other disorders of muscle, ligament, and fascia / Necrotizing fasciitis
729.2	Other disorders of soft tissue / Neuralgia, neuritis, and radiculitis, unspecified
729.6	Residual foreign body in soft tissue
730.06	Acute osteomyelitis / Lower leg
730.07	Acute osteomyelitis / Ankle and foot
730.16	Chronic osteomyelitis / Lower leg

730.17	Chronic osteomyelitis / Ankle and foot
730.26	Unspecified osteomyelitis / Lower leg
730.27	Unspecified osteomyelitis / Ankle and foot
730.96	Unspecified infections of bone / Lower leg
730.97	Unspecified infections of bone / Ankle and foot
732.5	Juvenile osteochondrosis of foot
733.40	Aseptic necrosis of bone / site unspecified
733.44	Aseptic necrosis of bone / Talus
733.81	Malunion of fracture
734	Flat foot
735.0	Acquired deformities of toe / Hallux valgus (acquired)
735.2	Acquired deformities of toe / Hallux rigidus
735.3	Acquired deformities of toe / Hallux malleus
736.71	Other acquired deformities of ankle and foot / Acquired equinovarus deformity
736.72	Other acquired deformities of ankle and foot / Equinus deformity of foot, Acquired
736.73	Other acquired deformities of ankle and foot / Cavus deformity of foot
736.75	Other acquired deformities of ankle and foot / Cavovarus deformity of foot, acquired
736.79	Other acquired deformities of ankle and foot / Other
754.50	Varus deformities of feet / Talipes varus
754.51	Varus deformities of feet / Talipes equinovarus
754.60	Valgus deformities of foot / Talipes valgus
754.61	Valgus deformities of foot / Congenital pes planus
754.69	Valgus deformities of foot / Other
754.70	Other deformities of feet / Talipes, unspecified
754.79	Other deformities of feet / Other
755.67	Anomalies of foot, not elsewhere classified
785.4	Symptoms involving cardiovascular system / Gangrene
824	Fracture of ankle / Medial malleolus, closed
824.1	Fracture of ankle / Medial malleolus, open
824.2	Fracture of ankle / Lateral Malleolus, closed
824.3	Fracture of ankle / Lateral Malleolus, open
824.4	Fracture of ankle / Bimalleolar, closed
824.5	Fracture of ankle / Bimalleolar, open
824.6	Fracture of ankle / Trimalleolar, closed
824.7	Fracture of ankle / Trimalleolar, open
824.8	Fracture of ankle / Unspecified, closed
824.9	Fracture of ankle / Unspecified, open
825.0	Fracture of one or more tarsal and metatarsal bones / Fracture of calcaneus, closed
825.1	Fracture of one or more tarsal and metatarsal bones / Fracture of calcaneus, open
825.20	Fracture of other tarsal and metatarsal bones, closed / Unspecified bone(s) of foot (except toes)
825.21	Fracture of other tarsal and metatarsal bones, closed / Astragalus

825.22	Fracture of other tarsal and metatarsal bones, closed / Navicular (scaphoid), foot
825.23	Fracture of other tarsal and metatarsal bones, closed / Cubiod
825.24	Fracture of other tarsal and metatarsal bones, closed / Cuneiform, foot
825.25	Fracture of other tarsal and metatarsal bones, closed / Metatarsal bone(s)
825.29	Fracture of other tarsal and metatarsal bones, closed / Other
825.30	Fracture of other tarsal and metatarsal bones, open / Unspecified bone(s) of foot (except toes)
825.31	Fracture of other tarsal and metatarsal bones, open / Astragalus
825.32	Fracture of other tarsal and metatarsal bones, open / Navicular (scaphoid), foot
825.33	Fracture of other tarsal and metatarsal bones, open / Cubiod
825.34	Fracture of other tarsal and metatarsal bones, open / Cuneiform, foot
825.35	Fracture of other tarsal and metatarsal bones, open / Metatarsal bone(s)
825.39	Fracture of other tarsal and metatarsal bones, open / Other
826.0	Fracture of one or more phalanges of foot / Closed
826.1	Fracture of one or more phalanges of foot / Open
827.0	Other, multiple, and ill-defined fractures of lower limb / Closed
827.1	Other, multiple, and ill-defined fractures of lower limb / Open
838.00	Closed dislocation / Foot unspecified
838.01	Closed dislocation / Tarsal (bone), joint unspecified
838.02	Closed dislocation / Midtarsal (joint)
838.03	Closed dislocation / Tarsometatarsal (joint)
838.04	Closed dislocation / Metatarsal (bone), joint unspecified
838.05	Closed dislocation / Metatarsophalangeal (joint)
838.06	Closed dislocation / Interphalangeal (joint), foot
838.09	Closed dislocation / Foot, other
838.10	Open dislocation / Foot unspecified
838.11	Open dislocation / Tarsal (bone), joint unspecified
838.12	Open dislocation / Midtarsal (joint)
838.13	Open dislocation / Tarsometatarsal (joint)
838.14	Open dislocation / Metatarsal (bone), joint unspecified
838.15	Open dislocation / Metatarsophalangeal (joint)
838.16	Open dislocation / Interphalangeal (joint), foot
838.19	Open dislocation / Other
845.09	Sprains and strains of ankle and foot / Other
845.10	Sprains and strains of foot / Unspecified site
891.1	Open wound of knee, leg (except thigh), and ankle / Complicated
892.0	Open wound of foot except toe(s) alone / Without mention of complication
916.3	Superficial injury of hip, thigh, leg, and ankle / Blister, infected
917.2	Superficial injury of foot and toe(s) / Blister without mention of infection
917.3	Superficial injury of foot and toe(s) / Blister, infected
924.20	Contusion of lower limb and of other and unspecified sites / Foot
924.3	Contusion of lower limb and of other and unspecified sites / Toe
959.7	Injury, other and unspecified / Knee, leg, ankle, and foot

991.5	Effects of reduced temperature / Chilblains
996.60	Infection and inflammatory reaction due to unspecified device, implant, and graft
997.2	Peripheral vascular complications
998.32	Disruption of external operation (surgical) wound
998.59	Other postoperative infection
998.83	non-healing surgical wound

C. Procedure Codes

Providers must bill the appropriate CPT codes that accurately describe the services rendered. CPT codes must be billed to the highest level of specificity.

Note: Services of a podiatrist provided to a recipient on that recipient's first visit to the practice when billed with a new patient office visit code (99201-99205), will not deny for inappropriate diagnosis. Providers may bill one unit per date of service for the above procedure codes.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The unit of service is determined by the appropriate procedure code(s) used.

F. Place of Service

Inpatient, outpatient and office.

G. Co-payments

Podiatry services are subject to co-payment for office visits for recipients age 21 and over. For additional information on co-payments and co-payment exemptions, refer to the *Basic Medicaid Billing Guide* on DMA's Web site at <http://www.dhhs.state.nc.us/dma/basicmed/>

H. Reimbursement

Providers shall bill their usual and customary charges.