

Table of Contents

1.0	Description of the Service.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
2.3	Recipients with Medicaid for Pregnant Women.....	2
3.0	When the Service Is Covered.....	2
4.0	When the Service Is Not Covered.....	2
4.1	General Criteria.....	3
4.2	Routine Foot Care.....	3
5.0	Requirements for and Limitations on Coverage.....	3
5.1	Prior Approval.....	3
6.0	Providers Eligible to Bill for the Service.....	3
7.0	Additional Requirements.....	3
8.0	Policy Implementation/Revision Information.....	4
	Attachment A: Claims-Related Information.....	5

1.0 Description of the Service

Podiatry is the surgical, medical, or mechanical treatment of 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 anesthetic, and 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

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/medbillcaguide.htm>

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

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 **Section 5.1** for service requirements.

3.0 When the 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, see **Section 2.0** of this policy.

Medicaid covers podiatry services when they are medically necessary and

- a. the 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 service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

4.0 When the 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, see **Section 2.0** of this policy.

4.1 General Criteria

Podiatry services 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 duplicates another provider's procedure; or
- d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Routine Foot Care

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, see **Section 2.0** 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

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for medically necessary routine foot care when the procedures are within the scope of their practice.

7.0 Additional Requirements

Medical record documentation must support the services rendered.

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

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

Podiatrists, physicians, and nurse practitioners enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.

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.

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. For example: the destruction of plantar warts must be billed with CPT procedure codes 17000, 17003, 17004.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Podiatry services may be performed in the following places:

Place of Service Code	Description
03	School
05	Indian Health Service free-standing facility
06	Indian Health Service provider-based facility
11	Office
12	Home (private residence)
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room—hospital
24	Ambulatory surgery center
25	Birth center
26	Military treatment facility
31	Skilled nursing facility
33	Custodial care facility
34	Hospice
50	Federally qualified health center (FQHC)
51	Inpatient psychiatric facility
52	Psychiatric treatment facility—partial hospitalization
53	Community mental health center
54	Intermediate care facility (ICF)
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center

61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End-stage renal disease treatment facility
71	State or local health department clinic/public health clinic
72	Rural health clinic

F. Reimbursement

Providers must bill usual and customary charges.

G. Co-payments

Podiatry services are subject to a \$3.00 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/medbillcaguide.htm>.