

Podiatry Services

This section describes the policy and billing instructions for podiatry services. For additional help, refer to the *Podiatry Services Billing Examples* section of this manual.

Notice: Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009) excluded various optional benefits from coverage under the Medi-Cal program, including podiatry services. Refer to the *Optional Benefits Exclusion* section in this manual for policy details, including information regarding exemptions to the excluded benefits. All codes listed in this section are affected by the optional benefits exclusion policy. Assistant surgeon services and orthotics and prosthetics remain reimbursable and are exempt from the exclusion policy.

The following information is an excerpt from *California Code of Regulations (CCR)*, Title 22.

Benefit Limitations (CCR, Section 51304)

Program coverage of services specified in Sections 51308, 51308.5, 51309, 51310, 51312, and 51331(a)(3) through (9), unless noted otherwise, is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.

Covered Services (CCR, Section 51310)

In addition to the policy described in the *Optional Benefits Exclusion* section, services provided by podiatrists, acting within the scope of their practice as authorized by California Law, are covered subject to the following:

- Podiatric office visits (CPT-4 codes 99201 – 99203 and 99211 – 99213) are covered as medically necessary subject to the availability of a Medi-Service reservation or authorization. Immediate or emergency podiatry surgery services that do not require a *Treatment Authorization Request (TAR)* are listed on a following page. All other podiatry services are subject to authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles or tendons that insert into the foot; that are secondary to or complicating chronic medical diseases; or that significantly impair the ability to walk.
- Outpatient podiatry services are limited to a maximum of two services in any one month unless authorization for additional services is obtained.
- Providers must obtain a retroactive TAR approval for podiatry services rendered on an emergency basis, except for those services listed under “Immediate or Emergency Services” in this section. Emergency services shall conform to and be in compliance with the provisions of Section 51056.
- Podiatry services rendered to acute hospital, Nursing Facility Level B (NF-B) or Level A (NF-A) inpatients are covered only when provided pursuant to an order on the patient’s chart, signed by the physician or podiatrist who admitted the patient, specifying the care to be given. Services to acute hospital NF-B or NF-A inpatients are further subject to authorization.

- Hospitalization of patients by podiatrists is subject to the procedures set forth in Section 51327. Podiatry services provided to hospital inpatients are covered only to the extent that the period of hospitalization is covered by the program.
- Routine nail trimming is not covered.

Definition of Emergency Services (CCR, Section 51056)

Emergency services are those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, that if not immediately diagnosed and treated would lead to disability or death.

Reimbursement for Podiatry Services (CCR, Title 22, Section 51505.1)

Reimbursement for podiatry services shall be the usual charges made to the general public not to exceed the maximum reimbursement rate listed in CCR, Title 22 for each procedure performed by a podiatrist. For additional information, see Section 51505.1(b), (c) and (d).

Immediate or Emergency Services

In compliance with *Welfare and Institutions Code (W&I Code)*, Section 14133.07, podiatrists are not required to obtain a *Treatment Authorization Request (TAR)* for the surgery services identified below.

These services are subject to post-payment medical records audits; therefore providers must retain appropriate documentation in their medical records.

<u>CPT-4 Codes</u>	<u>Surgery Service</u>
10060, 10160, 10180	Incision and drainage
11730, 11732	Nails
27650 – 27654, 27658 – 27698, 27704	Leg (tibia and fibula) and ankle joint: repair, revision and/or reconstruction
27760 – 27766, 27786 – 27829, 27840 – 27848	Leg (tibia and fibula) and ankle joint: fracture and/or dislocation
28415, 28430 – 28515	Foot and toes: fracture and/or dislocation
28190	Foot and toes: introduction or removal
28192, 28193	Foot and toes: introduction or removal

**Medi-Services and
TAR Requirements**

Podiatry services rendered in an outpatient setting must be billed with a Medi-Service reservation or an approved TAR.

Medi-Services Reservations

One Medi-Service for each date of service must be reserved. Information about how to reserve a Medi-Service is contained in the following documents:

- If using the Automated Eligibility Verification System (AEVS), refer to the *AEVS: Transactions* section in the Part 1 manual.
- If using a Point of Service (POS) device, refer to the *POS: Eligibility Transaction Procedures* section of the *POS Device User Guide*.
- If using the Internet, refer to the *Medi-Cal Web Site Quick Start Guide*.

Where to Submit TARs

All paper TARs for podiatry services must be submitted to the West Sacramento TAR Processing Center at the following address:

West Sacramento TAR Processing Center
820 Stillwater Road
West Sacramento, CA 95605-1630

West Sacramento TAR Processing Center
P.O. Box 13029
Sacramento, CA 95813-4029

**Authorization:
Orthotic and Prosthetic
(O&P) Services**

Authorization is required for Orthotic and Prosthetic (O&P) services when the cost exceeds specified TAR thresholds (limits). A TAR is required when the cumulative program cost for repair/maintenance, purchase or rental of orthotics exceeds \$250 or when prosthetics exceeds \$500.

TAR Documentation for
O&P

A copy of the prescription sent by an O&P provider must accompany the TAR submitted to the Sacramento Medi-Cal Field Office (SMCFO) and contain all the data listed below.

In addition to the practitioner's signature, the following information must be provided on the prescription form:

- Name, address and telephone number of the prescribing practitioner
- Date of prescription
- Item being prescribed
- California State license number of the prescribing practitioner
- Diagnosis that documents medical necessity

Unlisted O&P Equipment
or Services

Prior authorization is required for unlisted and "By Report" equipment or services, as appropriate, regardless of the dollar amount involved.

TAR Documentation for All
Podiatry Services Except
Orthotic and Prosthetic
(O&P)

The following information must be submitted with the TAR:

- Where applicable, proof that Medi-Service reservations have been exhausted
- A signed physician order/referral specifying care to be given for inpatient services rendered in an acute hospital or nursing facility
- X-rays for instances of either osseous surgery or soft tissue surgical procedures, when it further documents the deformity
- Clinical records of care that document conservative treatment, thereby medically justifying the procedure(s) requested

Prior Authorization:
Inpatient Services

Services rendered in an inpatient setting (such as a hospital or Long Term Care facility) must have prior authorization, and the recipient must be Medi-Cal eligible for the month of service.

Prior Authorization:
Emergency Services

Podiatry services rendered on an emergency basis must be billed with retroactive authorization, except for those services listed under “Immediate or Emergency Services” in this section, and the recipient must be eligible for the month of service.

The chart on a following page illustrates podiatry Medi-Services and TAR requirements by service type.

TAR Documentation
for Emergencies

Emergency services, except for those services listed under “Immediate or Emergency Services” in this section, require authorization. However, authorization may be obtained retroactively. Any service classified as an emergency must be justified by a physician or podiatrist’s statement. This comprehensive statement must describe the emergency, the patient’s condition and verify that the emergency services were immediately necessary. The statement must be signed by a physician or podiatrist with direct knowledge of the emergency described.

TAR Restrictions

Medi-Cal field office TAR approval is restricted to the following conditions:

- Disorders of the feet secondary to or complicated by chronic disease
- Disorders of the feet, which significantly impair the ability to walk

Nail Debridement

CPT-4 codes 11720 (debridement of nail[s] by any method[s]; one to five) and 11721 (...six or more) must be billed in conjunction with a primary diagnosis code that meets the TAR restrictions outlined in this section.

Claims must also include ICD-9-CM code 110.1 (dermatophytosis of nail) as the secondary diagnosis code.

These services require a TAR.

Podiatrists submitting claims for CPT-4 codes 11720 or 11721 must include the referring physician’s name in the *Name of Referring Provider or Other Source* field (Box 17) and NPI in Box 17B of the *CMS-1500* claim or the *Attending NPI* field (Box 76) of the *UB-04* claim.

Podiatry Medi-Services and TAR Requirements by Type of Service Chart

<u>Type of Service</u>	<u>Medi-Service/TAR Requirement</u>
Initial or established office visit (CPT-4 codes 99201 – 99203 and 99211 – 99213) in office or clinic	Medi-Service reservation or approved TAR
Other outpatient services rendered in any setting	Approved TAR
Inpatient services rendered in a hospital	Approved TAR
Laboratory/Radiology services (CPT-4 codes)	The following essential laboratory and radiology procedures may be included under a Medi-Service reservation when billed in conjunction with CPT-4 codes 99201 – 99203 or 99211 – 99213: <u>Essential Laboratory and Microbiology Procedures (CPT-4 codes)</u> 81000 – 81003, 82948, 87101, 87106, 87181, 87184 <u>Essential Radiological Procedures</u> 73600, 73610, 73620, 73630, 73650, 73660
Durable Medical Equipment (DME)	Approved TAR. (Prior authorization is required when the cumulative cost for purchase of related items is more than \$100.) Note: If HCPCS code E1399 is used, a TAR is required in all cases. Claims for these items must be submitted using attached invoices. (DME HCPCS codes are in the <i>Medi-Cal Allied Health Services Provider Manual</i> .)
Orthotic and Prosthetic (O&P) services billed with HCPCS codes	Approved TAR Authorization is required for: <u>Orthotic services</u> (cumulative costs exceed \$250) <u>Prosthetic services</u> (cumulative costs exceed \$500)

**“By Report”
Requirements**

Items reimbursed “By Report” require the following information to be submitted with the claim:

- Item description
- Manufacturer name
- Model number
- Catalog number, if appropriate
- Suggested retail price
- Description of and justification for any special features (custom modifications or special accessories)
- The reason a listed code was not used, if using an unlisted code