Podiatry Services
## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 (Published: February 25, 2016)</td>
<td>New document</td>
<td>FSSA and HPE</td>
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<tr>
<td>1.1</td>
<td>Policies and procedures as of April 1, 2016 (Published: December 15, 2016)</td>
<td>Scheduled update</td>
<td>FSSA and HPE</td>
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<td>1.2</td>
<td>Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017 (Published: February 23, 2017)</td>
<td>CoreMMIS update</td>
<td>FSSA and HPE</td>
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<td>2.0</td>
<td>Policies and procedures as of October 1, 2017 (Published: February 15, 2018)</td>
<td>Scheduled update</td>
<td>FSSA and DXC</td>
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| 3.0     | Policies and procedures as of November 1, 2018 (Published: October 10, 2019) | Scheduled update:  
- Reorganized and edited text as needed for clarity  
- Incorporated relevant information from the *Medical Policy Manual*  
- Updated links to the new IHCP provider website  
- Modified the initial note box with standard wording  
- Added a definition of podiatry in the *Introduction* section and removed managed care information  
- Updated the *Prior Authorization for Podiatry Services* section, including removing outdated and superfluous information from 405 IAC 5-26  
- In the *Coverage, Billing, and Reimbursement for Podiatry Services* section, added note about maintaining documentation in the member’s record for podiatry consultations rendered in a nursing facility  
- Clarified the list of restrictions in the *Office Visits* section and added the restriction excluding extended or comprehensive podiatric office visits | FSSA and DXC |
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<tr>
<td></td>
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<td>Updated the criteria for routine foot care coverage in the <em>Routine Foot Care</em> section and added statement that PA is not required</td>
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<td>Removed specific reimbursement information from the <em>Surgical Services</em> section</td>
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<td>Updated the <em>Confirmatory Consultation</em> section (formerly <em>Second Opinions</em>)</td>
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<td>Added IAC reference in the <em>Laboratory and X-Ray Services</em> section</td>
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<td>Updated the <em>Orthopedic or Therapeutic Footwear</em> section</td>
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<td>Added the <em>Community Health Worker Services</em> section</td>
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Podiatry Services

Note: For updates to coding, coverage, and benefit information, see IHCP banner pages and bulletins, available from the News, Bulletins, and Banner Pages page at in.gov/medicaid/providers.

The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member’s MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.

Introduction

Podiatry is a specialized practice focusing on the study and care of the foot and related structures, including its anatomy, pathology, and medical and surgical treatment.

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 of particular benefit plans and the restrictions and billing requirements described in this document.

Prior Authorization for Podiatry Services

The Indiana Administrative Code (IAC) should be used as the primary reference for prior authorization (PA) requirements. 405 IAC 5-26 contains specific criteria pertaining to PA for podiatry services, including PA guidelines for corrective features built into shoes, comparative foot x-rays, and surgical procedures performed within the scope of the podiatrist’s license. Prior authorization is required for hospitals stays, as outlined in 405 IAC 5-17.

Coverage, Billing, and Reimbursement for Podiatry Services

The following sections describe coverage requirements, billing procedures, and reimbursement policies for various types of podiatry services. For general billing instructions, see the Claim Submission and Processing module.

IHCP reimbursement for podiatrists (provider specialty 140) is limited to the Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in Podiatry Services Codes on the Code Sets page at in.gov/medicaid/providers.

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. Documentation must be maintained in the member’s medical record.

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Office Visits

In accordance with 405 IAC 5-26-7, the IHCP covers podiatric office visits, subject to the following restrictions:

- The IHCP limits reimbursement for podiatric office visits to one 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 – Podiatrist 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.

- The IHCP limits reimbursement for new patient office visits (procedure code 99201, 99202, or 99203) to one per member per provider per 3-year period. (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 3 years.)

- IHCP reimbursement is not available for extended or comprehensive podiatric office visits. Podiatrist reimbursement is limited to the procedure codes listed in Podiatry Services Codes on the Code Sets page at in.gov/medicaid/providers.

**Note:** The Family and Social Services Administration (FSSA) Program Integrity staff 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 FSSA Program Integrity staff 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 FSSA Program Integrity to arrange for repayment.

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 only when both of the following conditions apply:
  - 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.

The IHCP covers routine foot care, up to a maximum of six services per 12-month period, only when all the following criteria are met:

- The member has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous.
- The systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.
- A medical doctor or doctor of osteopathy has seen the member for treatment or evaluation of the systemic disease during the 6-month period before the routine foot care service is rendered.
PA for routine foot care is not required. However, providers must include the name and National Provider Identifier (NPI) of the physician who saw the member for the systemic disease in the referring provider fields on the professional claim. Providers must 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. The International Classification of Diseases (ICD) diagnosis codes for systemic conditions that justify coverage for routine foot care, as well as applicable CPT and HCPCS procedure codes, are listed in Podiatry Services Codes on the Code Sets page at in.gov/medicaid/providers.

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

**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.

**Confirmatory Consultation**

The IHCP may require podiatrists to obtain a confirmatory consultation, in accordance with the guidelines in 405 IAC 5-8-4, to establish the medical necessity for the following surgical procedures:

- Bunionectomy procedures
- All surgical procedures involving the foot

A confirmatory consultation is required regardless of the setting in which the surgery is performed, including ambulatory surgical centers, hospitals, clinics, or offices.

**Billing for Podiatric Surgical Procedures**

For podiatric surgical procedures, including diagnostic surgical procedures, providers cannot fragment and bill separately. Generally, such procedures are included 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 reimburse podiatrists 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. In addition, a podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory, in accordance with 405 IAC 5-18.

The IHCP covers the following lab and x-ray services billed by a podiatrist:

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

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

Doppler Evaluations

The IHCP covers 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

The IHCP covers orthotic services.

With a physician’s written order, the IHCP covers the following items for members of all ages:

- 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, wedges, arch supports, and inserts.

Providers should use designated “diabetics only” HCPCS codes to bill for therapeutic shoes, as well as modifications and inserts, when provided to members with severe diabetic foot disease. See the Procedure Codes for Orthotics for Severe Diabetic Foot Disease table in the Podiatry Services Codes on the Code Sets page at in.gov/medicaid/providers are the only codes that providers can use to bill for these services. Providers should not use these codes in any other circumstances.
Members are eligible for a total of three pairs of inserts each calendar year. Custom-molded shoe codes include the insert. Therefore, the IHCP allows for either of the following:

- One pair of custom-molded shoes and two additional pairs of inserts
- One pair of depth-inlay shoes and three pairs of inserts

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.

For each code, one unit equals one shoe or insert. If a member needs a pair of shoes or inserts, providers should submit the claim using the appropriate HCPCS code with “2” as the unit of service.

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.

**Note:** The IHCP allows separate reimbursement of certain orthotic and prosthetic codes when rendered in an outpatient facility setting. See the Durable and Home Medical Equipment and Supplies module for more information.

### Community Health Worker Services

For dates of service on or after July 1, 2018, the IHCP covers community health worker (CHW) services when the CHW meets certification requirements, is employed by an IHCP-enrolled billing provider, and renders the service under the supervision of a qualifying IHCP-enrolled provider type, which includes podiatrists. The supervising provider’s NPI should be indicated as the rendering provider on the claim. The CHW’s name must be included in the claim notes.

The following procedure codes are covered for billing CHW services:

- 98960 – Self-management education & training, face-to-face, 1 patient
- 98961 – Self-management education & training, face-to-face, 2–4 patients
- 98962 – Self-management education & training, face-to-face, 5–8 patients

The IHCP limits reimbursement for CHW services to 4 units (2 hours) per day and 24 units (12 hours) per month per member.

Services provided by a CHW are reimbursed at 50% of the Professional Fee Schedule amount.