



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Podiatry Services

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Revision History

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1.1	Policies and procedures as of April 1, 2016 Published: December 15, 2016	Scheduled update	FSSA and HPE
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4.0	Policies and procedures as of February 1, 2020 Published: September 24, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of February 1, 2021 Published: June 10, 2021	Scheduled update: <ul style="list-style-type: none"> • Edited text as needed for clarity • In the Office Visits section: <ul style="list-style-type: none"> – Updated the limit for podiatry office visits from “per 12 months” to “per calendar year” and updated the description for the related system audit (6090) – Removed CPT code 99201 • In the Routine Foot Care section, updated the limit for routine foot care from “per 12-month period” to “per calendar year” • In the Surgical Services section, clarified language about confirmatory consultations to align with 405 IAC 5-26-10 • In the Laboratory and X-Ray Services section, added information about laboratory services reimbursed for podiatrists 	FSSA and Gainwell

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Podiatry Services

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member services – providers must contact the member’s managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) 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 limits 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 requirements. 405 IAC 5-26 contains specific criteria pertaining to prior authorization for podiatry services, including 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 hospital 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^{®1}) and Healthcare Common Procedure Coding System (HCPCS) procedure codes listed in *Podiatry Services Codes* accessible from 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 podiatry office visits to one per calendar year per member. *(Note: For dates of service prior to October 1, 2020, this limit was calculated based on a rolling 12-month period rather than by calendar year.)*
Additional visits may be billed only if a significant additional problem is addressed. Prior authorization does not allow claims to override system audit 6090 – *Indiana Medicaid benefits allow payment for one (1) podiatry office visit per recipient per calendar year.* 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 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 99202 or 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 are present:
 - Clinical evidence of infection of the toenail
 - Compelling medical evidence 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 calendar year, 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.

Prior authorization is not required for routine foot care. 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 prior authorization:

- 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 prior authorization, as specified in *405 IAC 5-26*.

Based on the facts of the case, the IHCP may require podiatrists to obtain a confirmatory consultation in accordance with *405 IAC 5-8-4* to substantiate the medical necessity of the service or approach for the following surgical procedures:

- Bunionectomy procedures
- All surgical procedures involving the foot

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

When billing 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. The 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

As indicated in *Podiatry Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers, any IHCP-covered laboratory procedure code within code range 80047–89398 is reimbursable for podiatrists if the service is medically necessary, within their scope of practice, and allowable under their Clinical Laboratory Improvement Amendment (CLIA) certification.

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 limits:

- 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 calendar 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, modifications, and inserts when provided to members with severe diabetic foot disease. The only codes that providers can use to bill for these services are listed in the *Procedure Codes for Orthotics for Severe Diabetic Foot Disease* table in *Podiatry Services Codes* on the [Code Sets](#) page at in.gov/medicaid/providers. 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 depth-inlay shoes and three pairs of inserts per calendar year
- One pair of custom-molded shoes and two additional pairs of inserts per calendar year

In addition, the following HCPCS codes for inserts for diabetics only have limits on the number of units allowed per date of service:

- A5512 allows a maximum of six units per date of service.
- A5513 allows a maximum of two units 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

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. Podiatry-supervised CHW services are covered only when such services are necessitated by a condition-related diagnosis approved for podiatrist billing. Prior authorization is not required.

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 per member
- 24 units (12 hours) per month per member

Services provided by a CHW are reimbursed at 50% of the resource-based relative value scale (RBRVS) amount. For current IHCP reimbursement rates, see the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.