519.13 PODIATRY SERVICES

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BACKGROUND

West Virginia Medicaid coverage of podiatric services is limited to the examination, diagnosis, treatment, prevention, and care of conditions and functions of the foot and ankle. These services must be provided by an individual currently licensed under West Virginia law to practice podiatry, or under the laws of the State where the practice is conducted, and is eligible to participate in the West Virginia Medicaid Program.

POLICY

519.13.1 COVERED SERVICES

West Virginia Medicaid covers the following foot and ankle care services when medically necessary and appropriate in accordance with West Virginia Code Chapter 30, Article 3, Section 4. Prior authorization and service limits may apply.

- Treatment services for acute conditions such as infections, inflammations, and ulcers
- Surgeries for such conditions as bunions, exostoses, hammertoes, neuromas and ingrown toenails
- Reduction of fractures and dislocations of the foot and ankle
- Surgical correction of a subluxated foot structure, if all of the following are met:
    - It is an integral part of the treatment of a foot injury
    - It is performed to improve function of the foot
    - It alleviates an induced or associated symptomatic condition
- Treatment of symptomatic conditions associated with partial displacement of the foot/ankle. Symptomatic conditions include:
    - Osteoarthritis
    - Bursitis
    - Bunions
    - Tendonitis
- Treatment of sprains and strains
- Treatment of plantar warts
- Debridement of mycotic nails for members with clinical evidence of mycosis as documented on a culture report from a laboratory that states the specific organism identified, and marked limitation in ambulation that requires active treatment of the nails.
- Orthotics necessary for treatment of the foot and ankle:
    - Foot rest, removable, molded to member model
    - Orthopedic footwear, custom molded shoe, removable inner mold, orthotic shoe, and modifications
    - Therapeutic shoes and inserts for members with severe diabetic foot disease and provided for the purpose of averting amputation
    - For custom fabricated orthoses, there must be documentation in the podiatrist's records to support the medical necessity of that type of device rather than a prefabricated orthosis. This information must be available to the Bureau for Medical Services on request.
    - Reimbursement for orthotics:
        - All codes for orthoses or repairs of orthoses billed with the same date of service must be submitted on the same claim.

  - Reimbursement may be made for a visit to determine a need for therapeutic shoes, inserts, or modifications if the podiatrist documents that the purpose of such visit was not solely to fit or dispense the shoe, insert, or modification. A podiatrist called in (e.g., nursing facility) by the attending practitioner should bill specific codes for services rendered, i.e. consultation, minor surgeries, etc.
  - There is no separate reimbursement for fitting, evaluation, measurement, casting, fabrication, follow-up, or adjustment of therapeutic shoes, inserts or modifications, or for the certification of need or prescription of the footwear.
- Evaluation and management services and covered treatment services provided to members who are inpatients of a hospital
- Covered treatment/surgical services, except screening services, provided to members who are residents of a nursing home
- Non-invasive peripheral vascular studies for pre-operative evaluation of members with diabetes or other signs of peripheral vascular disease. The covered studies include non-invasive physiologic studies of the lower extremity arteries, with or without provocative functional maneuvers, and duplex scan of the lower extremity arteries or arterial bypass grafts.
- Medically necessary laboratory and radiology services applicable to foot and ankle care and within the scope of podiatry state licensure.

519.13.1.1 Foot Care

Coverage of foot care services is limited to members diagnosed with the following medical conditions, when documented evidence exists that unskilled care would place the member at increased risk of infection or greater harm:

- Diabetes
- Chronic thrombophlebitis
- Peripheral neuropathies
- Arteriosclerosis of the extremities and
- Thromboangitis obliterans

In addition to the above covered diagnoses, the severity of the condition must be established and supported by clinical findings in conjunction with the practitioner, as follows:

Class A:

A finding of “non-traumatic amputation of foot or integral skeletal portion.”

Class B:

Any two findings of:

- Absent posterior tibial pulse
- Advanced tropic changes, such as decrease in hair growth, nail thickening, discolorations, thin or shiny texture and reddening of skin color (three of these are required)
- Absent dorsalis pedis pulse.

Class C:

Combination of one from Class B and two from Class C or, one finding from the preceding list and two findings of:

- Claudication
- Temperature changes, such as cold feet
- Edema
- Abnormal spontaneous sensations in the feet
- Burning

When billing for the above services, use the appropriate modifier from the list below:

- Q7 One Class A finding.
- Q8 Two Class B findings.
- Q9 One Class B and two Class C findings.

Based on medical necessity, the types of foot care that may be covered include:

- The cutting or removal of corns or calluses;
- The trimming, cutting, clipping, or debriding of toe nails.

The severity of the condition requiring foot care must be established and supported by pertinent clinical findings in conjunction with the documentation from the treating practitioner. West Virginia Medicaid follows CMS' classification of clinical findings that indicate severe peripheral involvement. For additional information refer to *Medicare Benefit Policy Manual Chapter 15, Section 290 - F Presumption of Coverage* at www.cms.gov/manuals/Downloads/bp102c15.pdf.

A written referral to the podiatrist from an enrolled practitioner who has treated the member (including those in the inpatient setting and residents of nursing homes) during the past 6 months must be included in the member's medical record.

Refer to *Chapter 506, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)* for specific codes, coverage, and limitations.

519.13.2 PRIOR AUTHORIZATION

All requests for covered services requiring prior authorization must be submitted to the UMC for medical necessity determination. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by BMS, is utilized for reviewing medical necessity of services requested.

To request prior authorization, the podiatrist must access the BMS Utilization Management Contractor's (UMC) web-based portal.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive West Virginia Medicaid eligibility.

Refer to *Chapter 100, General Administration and Information* for additional information.

519.13.3 NON- COVERED SERVICES

Non-Covered services include, but are not limited to:

- Treatment and supportive devices for flat foot conditions, regardless of underlying pathology.
- Treatment of subluxations of the foot; i.e., correcting a subluxated structure in the foot as an isolated entity.
- Routine foot care performed in the absence of localized illness, injury, or symptoms involving the foot.
- Therapeutic shoes, inserts and/or modifications that are provided to members who do not meet the coverage criteria.
- Consultations or visits when the sole purpose of the encounter is to dispense or fit the shoes.
- Deluxe features of any kind.
- Telephone calls/consultations including, but not limited to, information or services provided to a member or on her/his behalf.
- Services/items for the convenience of the patient or caretaker.
- Failed appointments, including, but not limited to, missed or canceled appointments.
- Time spent in preparation of reports.
- A copy of medical report when the DHHR or the Bureau paid for the original service.
- Experimental services or drugs.
- Research/study projects.
- Services/items that are not the least costly that will meet patient's medical needs.
- Services rendered outside the scope of a provider's license.
- Treatment in a podiatrist's office, etc., when the patient is able to do self-care at home.
- Denial of services by a primary payer for "not medically necessary" or "deemed not medically necessary."
- Conscious sedation, local anesthesia, regional anesthesia, IV sedation are non-covered. These are included in the procedure/service being provided.
- The cost of drugs dispensed by a podiatrist is considered to be included in the podiatric service charge and is not payable as an additional item of service.

Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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Custom Orthopedic Shoes: Shoes that are custom molded and manufactured according to the member's specifications and prescribed by a practitioner, doctor of osteopathy, nurse practitioner, or podiatrist.

Podiatric Services: The foot and ankle services provided by a podiatrist licensed to provide such services in the State of West Virginia. For provision of ankle surgery, the podiatrist must have hospital privileges granted by the hospital's medical staff credentialing committee.

Routine Foot Care: Any service performed involving the foot in the absence of localized illness, injury, or symptoms. Routine foot care includes, but is not limited to, such services as: cutting or removal of corns, calluses or warts (excluding plantar warts); treatment of a fungal (mycotic) toenail infection; the trimming of nails, including mycotic nails; cleaning and soaking of feet; applications of topical medication or skin creams; and other hygienic and preventive maintenance care in the realm of self-care.

Subluxation Of The Foot: The partial dislocation or displacement of joint surfaces, tendons, ligaments or muscles.

REFERENCES

The West Virginia State Plan references podiatry services at sections 3.1-A(6)(a), 3.1-B(6)(a), supplement 2 to attachments 3.1-A and 3.1-B(6)(a) and reimbursement at 4.19-B(6).

West Virginia State Code Chapter 30, Article 3, Section 4

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Podiatry Services		January 15, 2016