CHAPTER 57

PODIATRY SERVICES

Authority

N.J.S.A. 30:4D–6b, 30:4D–7, 7a, b, and c; 30:4D–12.

Source and Effective Date

R.1996 d.60, effective February 5, 1996.
See: 27 N.J.R. 4223(a), 28 N.J.R. 1015(a).

Executive Order No. 66(1978) Expiration Date

Chapter 57, Podiatry Services, expires on February 5, 2001.

Chapter Historical Note

Chapter 57, Podiatry Services Manual, became effective June 1, 1971 as R.1971 d.66. See: 3 N.J.R. 43(c), 3 N.J.R. 109(b). The provisions of Subchapter 2, Podiatry Billing Procedures, were adopted by R.1974 d.222, effective September 15, 1974. See: 6 N.J.R. 264(c), 6 N.J.R. 35(c). Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted by R.1986 d.52, effective March 3, 1986. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Pursuant to Executive Order No. 66(1978), Chapter 57 was readopted as R.1991 d.129, effective February 13, 1991. See: 22 N.J.R. 3439(b), 23 N.J.R. 858(b).

Chapter 57, Podiatry Services Manual, was repealed, and Chapter 57, Podiatry Services, was adopted as new rules, by R.1996 d.60, effective February 5, 1996. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

10:57–1.1 Introduction

(a) This chapter is concerned with the provision of podiatric services by a person licensed to practice podiatry in accordance with the New Jersey Medicaid program policies and procedures and the standards of practice as defined by the laws of the State of New Jersey (N.J.S.A 45:5) and the American Podiatric Medical Association.

(b) An approved New Jersey Medicaid provider of podiatric services may be reimbursed for medically necessary covered services provided within the scope of her or his license, and her or his approved New Jersey Medicaid Program Provider Agreement.

(c) A podiatrist may enroll in the New Jersey Medicaid program and provide covered, medically necessary services as an independent practitioner, or may provide such services as part of another entity, such as a hospital or clinic, physician group practice, or a mixed practitioner practice or under the managed care program.

10:57–1.2 Scope of services

Podiatry care under the Medicaid program is allowable to covered persons if such services are essential. Essential podiatry care includes those services which require the professional knowledge and skill of a licensed podiatrist. For recipients in the Medically Needy Program, podiatry care is only available to pregnant women, and the aged, the blind or disabled. (For information on how to identify a covered person, please refer to N.J.A.C. 10:49–2.)

10:57–1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Flat–foot conditions" means the local condition of flattened arches regardless of the underlying etiology. Treatment of flat-foot conditions encompasses all phases of services in connection with flat feet.

"Podiatrist" means a doctor of podiatric medicine licensed to practice podiatry by the New Jersey State Board of Medical Examiners, or similarly licensed by a comparable agency in the state in which he or she practices.

"Podiatry services" means those services performed by a licensed podiatrist within the scope of practice as defined by the laws of the State of New Jersey (N.J.S.A 45:5–7) and

which are within the scope of the services covered by the New Jersey Medicaid program.

"Routine foot care" means the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone for both ambulatory and bedfast patients, and any services performed in the absence of localized illnesses, injury or symptoms involving the foot.

"Specialist" for purposes of the New Jersey Medicaid program, means a fully licensed podiatrist who:

1. Is a diplomate of the appropriate specialty board as recognized by the American Podiatric Medical Association; or

2. Has been notified of board eligibility by the appropriate specialty board as recognized by the American Podiatric Medical Association.

"Subluxation" means the structural misalignment of the joints of the feet which do not require surgical methods of treatment and/or correction, with the exception of fractures and complete dislocations.

10:57–1.4 Provisions for provider participation

(a) In order to participate in the Medicaid program a podiatrist shall apply to and be approved by the New Jersey Medicaid program. Application for approval by the New Jersey Medicaid program requires completion and submission of the "Medicaid Provider Application" (FD–20) and the "Medicaid Provider Agreement" (FD–62).

1. The documents referenced above are located as Forms #8 and #9 in the Appendix at the end of the Administration Chapter (N.J.A.C. 10:49), and may be obtained from and submitted to:

Unisys Corporation
Provider Enrollment
P.O. Box 4804
Trenton, New Jersey 08650–4804

(b) In order to be approved as a Medicaid participating provider, the podiatrist shall be licensed by the State of New Jersey Board of Medical Examiners (See N.J.A.C. 13:35–3).

1. An out-of-State podiatrist must have comparable documentation under the applicable State requirements of the state in which the services are provided.

(c) In order to be approved as a specialist under the Medicaid program, a licensed podiatrist shall possess either of the following:

1. A specialty certification/permit issued by the specialty board as recognized by the American Podiatric Medical Association; or

2. A copy of the notification of board eligibility by the specialty board as recognized by the American Podiatric Medical Association.

(d) A photocopy of the current license, certification/permit or notification of board eligibility by the specialty shall be provided at the time of the application for enrollment.

10:57–1.5 Prior authorization

(a) Authorization by the Podiatry Services Unit ("Unit"), Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625, shall be obtained prior to the provision of the following services:

1. All orthopedic footwear;

2. Custom molded foot or ankle orthoses;

3. Routine debridement of toenails, more than once every two months.

(b) A written request for authorization (Form FD–356) shall be submitted, identifying the case and containing sufficient information about the problem and plan of treatment to enable the Unit to make a proper evaluation.

10:57–1.6 Basis of reimbursement

(a) Reimbursement for podiatry services covered under the New Jersey Medicaid program shall be on the basis of the customary charge, not to exceed a fixed fee schedule determined reasonable by the Commissioner of the Department of Human Services as specified at N.J.A.C. 10:57–3, and further limited by Federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

(b) For services rendered on or after February 10, 1995 to recipients eligible for both Medicare Part B and Medicaid, reimbursement will be made for the Medicare Part B coinsurance and deductible amounts or the Medicaid maximum allowable (less any third party payments including Medicare reimbursement), whichever is greater.

(c) Any podiatric physician who meets the above cited qualifications listed in N.J.A.C. 10:57–1.3 as a specialist and the requirements specified in N.J.A.C. 10:57–1.4 shall be eligible for specialist reimbursement.

10:57–1.7 Record keeping

(a) Podiatrists shall keep such individual records as are necessary to fully disclose the kind and extent of the services provided and shall make such information available as the Division or its agents may request. For the initial examination, the following documentation shall be on the record, regardless of the setting where the examination was performed:

1. Date of service;

2. Chief complaint(s);

3. Pertinent historical and physical data;

4. Reports of diagnostic procedures ordered or performed;

5. Diagnosis;

6. Prescription (including medication) and treatment.

(b) Progress notes may be brief but shall include date(s) of service, changes in patient condition, specific medications and/or other treatments.

SUBCHAPTER 2. PROVISION OF SERVICES

10:57–2.1 Covered and non-covered services

(a) The following foot care services shall not be covered:

1. Flat–foot conditions:

i. Exceptions:

(1) Treatment which is an integral part of post-fracture or postoperative treatment plan;

(2) Supportive devices (for example, arch supports, specific additions to shoes and the like) which are prescribed to palliate pain and other symptoms associated with the condition.

ii. Treatment where the talo-crural joint is involved;

iii. Treatment where there may be attachment of a supportive device to a brace or bar.

2. Subluxations of the feet in which the normal relationship of the bones, tendons, ligaments and supporting muscles is disturbed and which, regardless of underlying etiology, require treatment by mechanical methods (for example, whirlpool, paraffin baths, casting, strapping, splinting, padding, shortwave or low voltage currents, physical therapy, exercise manipulation, massage, and the like):

i. Exceptions:

(1) Where treatment is an integral part of post-fracture or postoperative treatment plan;

(2) Where the talo-crural joint is involved;

(3) Where there may be attachment of a supportive device to a brace or bar.

3. Routine foot care, routine hygienic care:

i. Exceptions;

(1) Treatment of painful corns, calluses and warts;

(A) When treatments are in excess of one per month, the case shall be referred for evaluation to the podiatry unit of the Division of Medical Assistance and Health Services, CN–712, Mail Code #15 Trenton, New Jersey 08625.

(2) Treatment of the foot for Medicaid recipients with metabolic, neurological, and peripheral diseases (for examples, diabetes, mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis, peripheral neuropathies); and

(3) Treatment of fungal (mycotic) and other infections of the feet and toenails.

(b) The following guidelines limit the provision of (a)3 above.

1. The importance of preventive or hygienic care for patients with a systemic illness, such as peripheral vascular disease, diabetes, or with severe physical disability is recognized. These will be considered on an individual basis by the podiatry consultant.

2. If services ordinarily considered routine are performed at the same time as and as a necessary integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds and infections, they are covered.

3. Fungal (mycotic) and other infections of the feet and toenails require professional services which are outside the scope of "routine foot services." Diagnostic and treatment services for foot infections are covered in the same manner as services performed for infections occurring elsewhere on the body, and the same type of coverage rules apply.

4. Treatment of plantar warts that are symptomatic and/or cause disability will be considered a covered service.

10:57–2.2 General provisions

(a) For purposes of reimbursement, a podiatrist and/or physician; podiatrist and/or physicians' group; shared health care facility; or providers sharing a common record are considered a single provider.

(b) When reference is made in the CPT manual to Office or other outpatient services—new patient; Hospital inpatient services—initial hospital care; Nursing facility services—comprehensive nursing facility assessments; and Domiciliary, Rest home, or Custodial care services—new patient; the intent of Medicaid is to consider this service as the initial visit. When the setting for this initial visit is an office or residential health care facility, for reimbursement purposes it is limited to a single visit. Future use of this category of codes will be denied when the recipient is seen by the same physician, group of physicians, or involves a shared health care facility which is a group of physicians sharing a common record. Reimbursement for an initial

office visit also precludes subsequent reimbursement for an initial residential health care facility visit and vice versa.

1. Reimbursement for an initial office visit or initial residential health care facility visit will be disallowed, if a preventive medicine service, EPSDT examination or office consultation were billed within a 12–month period by a podiatrist, podiatric group, shared health care facility, or practitioner sharing a common record.

2. If the setting is a nursing facility or hospital, the initial visit concept will still apply for reimbursement purposes despite CPT reference to the term initial hospital care or comprehensive nursing facility assessments. Subsequent readmissions to the same facility may be reimbursed as initial visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. In instances when the readmission occurs within 30 or less days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified in the qualifier under the headings Subsequent hospital care or Subsequent nursing facility care.

3. Initial hospital visit during a single admission will be disallowed to the same physician, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service. It is also to be understood that in order to receive reimbursement for an initial visit, one of the minimum documentation requirements must be met.

i. HCPCS 99201 and 99202 are exceptions to the above requirements outlined in the qualifier for the initial visit. For HCPCS 99201 and 99202, the provider shall follow the qualifier applied to routine visit or follow-up care visit, for reimbursement purposes.

ii. When reference is made, in the CPT, to Office or other outpatient services—established patient; Hospital inpatient services—subsequent hospital care; Nursing facility services—subsequent nursing facility care; and Domiciliary, Rest home or Custodial care services—established patient; the intent of Medicaid is to consider this service as the Routine Visit or Follow–Up Care visit. The setting could be office, hospital, nursing facility or residential health care facility. In order to document the record for reimbursement purposes, a progress note for the noted visits should include the minimum documentation specified in N.J.A.C. 10:57–1.7.

iii. House call procedure codes refer to a podiatrist visit limited to the provision of podiatric care to an individual who would be too ill to go to a podiatrist's office and/or is "home bound" due to his/her physical condition. When billing for a second or subsequent patient treated during the same visit, the visit should be billed as a home visit.

10:57–2.3 Provisions regarding surgery

(a) Specific requirements for surgery procedures may be found at N.J.A.C. 10:57–3.2(b).

1. Certain surgical procedures are carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate entity not immediately related to other services, the provider may bill a value for Separate Procedure.

2. Complications or other circumstances requiring additional and unusual services concurrent with the procedure(s) or during the listed period of normal follow-up care, may warrant additional reimbursement on a fee-for-service basis.

3. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total reimbursement shall be the allowance of the primary procedure plus 50 percent of the allowance of the secondary procedure to a total maximum of 200 percent unless otherwise specified in this section.

4. Anesthesia services rendered to his or her patient by the operating podiatrist are considered part of the surgical procedure and will not receive any additional reimbursement.

5. Reimbursement will be made for an assistant surgeon when the service is medically necessary and when a duly qualified surgical resident or house physician is unavailable, and when the primary procedure performed has a procedure code specialist fee of at least $142.00. The allowance permitted is a maximum of 15 percent of the listed specialist fee. The minimum payment is $27.00.

10:57–2.4 Radiology services

(a) Specific requirements for radiology procedures may be found at N.J.A.C. 10:57–3.2(c).

1. Reimbursement will be made for the combined technical and professional component of the reimbursement for the procedure code notwithstanding any statement to the contrary in the narrative. It will be paid only to one provider and will not be broken down into its component parts.

10:57–2.5 Consultation policies

(a) A consultation is recognized for reimbursement only when performed by a specialist, as the term is defined at N.J.A.C. 10:57–1.3, who is recognized as such by this Program and the request has been made by or through the patient's attending physician or other licensed practitioner and the need for such a request would be consistent with good medical practice. Two types of consultation are recognized for reimbursement—comprehensive consultation and limited consultation.