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Chapter 57, Podiatry Services Manual, was repealed, and Chapter 57, Podiatry Services, was adopted as new rules, by R.1996 d.60, effective February 5, 1996.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 the practitioner's license, and the practitioner's 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.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).

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.

"CPT" means that edition of the Current Procedure Terminology most current at the time of reference, as published annually by the American Medical Association, Chicago, Illinois, unless otherwise specified in rule.

"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.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Added "CPT" definition.

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
PO 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, PO Box 712, Trenton, New Jersey 08625–0712, 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 or NJ KidCare 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, and prior to July 20, 1998, to beneficiaries eligible for both Medicare Part B and Medicaid or NJ KidCare, reimbursement will be made for the Medicare Part B coinsurance and deductible amounts or the Medicaid or NJ KidCare maximum allowable (less any third party payments including Medicare reimbursement), whichever is greater. Effective on July 20, 1998, payments shall only be made up to the Medicaid or NJ KidCare maximum allowable amount consistent with N.J.A.C. 10:49–7.3(c)1.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
In (a)1, changed the N.J.A.C. reference.

10:57–2.12 Pharmaceutical services

(a) All covered pharmaceutical services provided under the New Jersey Medicaid program shall be provided to Medicaid recipients within the scope of N.J.A.C. 10:49, Administration Chapter; N.J.A.C. 10:51, Pharmaceutical Services.

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:57–3.1 Introduction to the HCPCS procedure code system

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology (CPT) (American Medical Association, PO Box 10950, Chicago, IL 60610. Attention: Order Department) architecture, employing a five-position code and as many as two two-position modifiers. Unlike the CPT numeric design, the HCFA-assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference.

(b) HCPCS has been developed as a three-level coding system, as follows:

1. Level I codes: Narratives for these codes are found in CPT, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT for use primarily by physicians, podiatrists, optometrists, certified nurse-midwives, certified nurse practitioners and clinical nurse specialists, independent clinics and independent laboratories. Level I procedure codes, and fees for each, for which podiatrists may bill, can be found at N.J.A.C. 10:57–3.2.

2. Level II codes: These codes are assigned by HCFA for physician and non-physician services which are not in CPT. Narratives for these codes, and the fees for each, can be found at N.J.A.C. 10:57–3.3.

3. Level III codes: Level III codes identify services unique to the New Jersey Medicaid program. These codes are assigned by the Division to be used for those services not identified by CPT codes or HCFA-assigned codes. Narratives for these codes, and the fees paid for each, can be found at N.J.A.C. 10:57–3.4.

(c) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for independent clinic services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE." The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" and "MOD":

These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND = lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used.

An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

A = "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment.

E = "E" preceding any procedure code indicates that these procedures are excluded from multiple surgery pricing and, as such, should be reimbursed at 100 percent of the Medicaid maximum fee allowance, even if the procedure is done on the same patient by the same surgeon at the same operative session. The procedure codes are excluded indicating that office visit codes are not reimbursed in addition to procedure codes for surgical procedures.

L = "L" preceding any procedure code indicates that the complete narrative for the code is located in N.J.A.C. 10:57–3.3 or 3.4.

N = "N" preceding any procedure code means that qualifiers are applicable to that code. (See N.J.A.C. 10:57–3.5)

HCPCS CODE = HCPCS procedure code numbers.

MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's modifier codes for podiatry services are:

20 = Microsurgery: When the service is performed using the techniques of microsurgery, including the aid of an operating microscope, modifier '20' may be added to the surgical procedure.

22 = Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may

be identified by adding modifier '22' to the usual procedure number.

26 = Professional Component: Certain procedures are a combination of a physician and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number. If a professional component type service is keyed without the '26' modifier and a manual pricing edit is received, resolve the edit by adding the '26' modifier.

50 = Bilateral Procedure: Unless otherwise identified in the listing, bilateral procedures requiring separate incisions that are performed at the same operative session, should be identified by the appropriate five-digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier '50' to the procedure number.

51 = Multiple Procedures: When multiple procedures are performed at the same operative session, the major procedure may be reported as listed. The secondary, additional or lesser procedure(s) may be identified by adding the modifier '51' to the secondary procedure number(s).

52 = Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the podiatrist's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52' signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

62 = Two Surgeons: Under certain circumstances, the skill of two surgeons (usually with different skills) may be required in the management of a specific procedure. Under such circumstances the separate services may be identified by adding the modifier '62' to the procedure number used by each surgeon for reporting his or her services.

66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or podiatrists, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician or podiatrist with the addition of the modifier '66' to the basic procedure number used for reporting services.

75 = Concurrent Care Services Rendered By More Than One Physician Or Podiatrist: When the patient's condition requires the additional services of more than one physician or podiatrist, each physician or podiatrist may identify his or her services by adding the modifier '75' to the procedure code for the basic service performed.

76 = Repeat Procedure By Same Podiatrist: The podiatrist may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier '76' to the repeated service.

77 = Repeat Procedure By Another Podiatrist: The podiatrist may need to indicate that a basic procedure performed by another podiatrist had to be repeated. This situation may be reported by adding modifier '77' to be repeated service.

80 = Assistant Surgeon: Surgical assistant services are identified by adding this modifier '80' to the usual procedure number(s).

TC = When applicable, a charge may be made for the technical component alone. Under those circumstances the technical component is identified by adding the modifier 'TC' to the usual procedure code.

XE = Non-Medicare-Covered Service—to indicate a service provided to a Medicare/Medicaid recipient is not reimbursable by Medicare.

DESCRIPTION = Code narrative: Narratives for Level I codes are found in CPT. Narratives for Level II and III codes are found at N.J.A.C. 10:57–3.3 and 3.4, respectively.

FOLLOW-UP DAYS = Number of days for follow-up care which are considered as included as part of the procedure code for which no additional reimbursement is available.

MAXIMUM FEE ALLOWANCE = New Jersey Medicaid program's maximum reimbursement allowance. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to evaluate and price the service. Attach a copy of any additional information to the claim form.

(d) Listed in this subsection are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a podiatrist when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:57–1.7, Recordkeeping and 10:57–1.6, Basis of Reimbursement.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in this subchapter (N.J.A.C. 10:57–3.2, 3.3, 3.4).

iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "Maximum Fee Allowance" as noted with these procedure codes represents the maximum payment for the given procedure for the podiatrist. When submitting a claim, the podiatrist must always use her or his usual and customary fee.

(1) Listed values for all surgical procedures include the surgery and the follow-up care included in the maximum fee allowance for the period (indicated in days) in the column titled "Follow-Up Days."

v. The HCPCS procedure codes that are billable in conjunction with office visit codes are listed at N.J.A.C. 10:57–3.5, Qualifiers. (See the "N" designation in the "Indicator" column.)

vi. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

Amended by R.1998 d.248, effective May 18, 1998.
See: 30 N.J.R. 626(a), 30 N.J.R. 1812(b).
Updated HCPCS codes throughout.

10:57–3.2 HCPCS Procedure Codes and Maximum Fee Allowance

(a) MEDICINE