ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Podiatrist**

DATE: **October 1, 2008**

SUBJECT: **Provider Manual Update Transmittal #102**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100	10-1-06	201.100	10-1-08
202.000	3-15-05	202.000	10-1-08
211.000	8-1-04	211.000	10-1-08
212.000	8-1-04	212.000	10-1-08
214.100	10-13-03	214.100	10-1-08
214.200	10-13-03	214.200	10-1-08
215.000	10-13-03	215.000	10-1-08
221.300	10-13-03	221.300	10-1-08
242.100	5-1-08	242.100	10-1-08
242.410	4-1-07	242.410	10-1-08

Explanation of Updates

Section 201.100 is updated to reiterate and clarify the requirement of Podiatrists enrollment in Title XVIII – Medicare.

Section 202.000 is re-titled and updated to reflect the requirement of Podiatrists' enrollment in Title XVIII – Medicare, with added references to applicable policy.

Sections 211.000 through 214.200 are updated to correct terminology "recipient" to "beneficiary".

Section 215.000 is updated to include primary diagnosis Malignant Neoplasm ICD-9-CM code range 230.0 through 238.9 as exempt from benefit limits imposed for beneficiaries age 21 years and over.

Section 221.300 is updated to correct terminology "recipient" to "beneficiary".

Section 242.100 is updated to delete procedure code 15000 as it is non-payable by Arkansas Medicaid and to add procedure codes 29904, 29905, 29906, 29907, 36591, and 36592 that were added as part of the 2008 CPT Procedure Code Conversion.

Section 242.410 is updated to correct outdated information regarding Medicare/Medicaid crossover claims and procedures, with added references to applicable policy.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

201.100 Participation Requirements for Individual Podiatrists 10-1-08

Podiatrists must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program.

A. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

B. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

C. A provider must be licensed to practice podiatry services in his or her state.

1. A copy of the current state license must accompany the provider application and Medicaid contract.
2. A copy of subsequent state licensure renewal must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.
3. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.
4. Podiatrists must be enrolled and accept assignment in the Title XVIII – Medicare Program (see section 202.000).

D. The provider must submit Clinical Laboratory Improvement Amendments (CLIA) certification, if applicable. (Section 205.000 contains information regarding CLIA certification.)

202.000 Medicare Mandatory Assignment of Claims for Physician's Services 10-1-08

The Omnibus Budget Reconciliation Act of 1989 requires the mandatory assignment of Medicare claims for "physician" services furnished to individuals who are eligible for Medicare and Medicaid, including those eligible as Qualified Medicare beneficiaries (QMBs). According to Medicare regulations, "physician" services, for the purpose of this policy, are services furnished by physicians, dentists, optometrists, chiropractors and podiatrists.

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover Claim procedures.

NOTE: The podiatrist provider must notify the Provider Enrollment Unit of a Medicare identification number. View or print Provider Enrollment Unit contact information.

211.000 Introduction 10-1-08

A. The Arkansas Medicaid Program reimburses enrolled providers for the program covered medical care of eligible Medicaid beneficiaries.

B. Medicaid reimbursement is conditional upon providers' compliance with program policy as stated in provider manuals, manual update transmittals and official program correspondence.

C. All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of medical necessity. **View or print the Glossary.**

1. Service coverage will be denied and reimbursement recouped if a service is not medically necessary.
2. The finding of medical necessity may be made by any of the following:
   a. Medical Director for the Medicaid Program
   b. Quality Improvement Organization (QIO)
   c. Peer Review Committee for the Medicaid Program

212.000 Scope 10-1-08

A. The Arkansas Medicaid Program covers podiatrist services through 42 Code of Federal Regulations, Section 440.60.

B. Arkansas Medicaid covers podiatrist services for eligible Medicaid beneficiaries of all ages.

C. Podiatrist services require a primary care physician (PCP) referral.

D. Podiatrist services include, but are not limited to, office and outpatient services, home visits, office and inpatient consultations, laboratory and X-ray services, physical therapy and surgical services. Section 242.100 contains the full list of procedure codes applicable to podiatry services.

E. Many podiatrist services covered by the Arkansas Medicaid Program are restricted or limited.

1. Section 214.000 describes the benefit limits on the quantity of covered services clients may receive.
2. Section 220.000 describes prior-authorization requirements for certain services.

214.100 New Patient Visit 10-1-08

Providers are allowed to bill one new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

214.200 Medical Visits and Surgical Services 10-1-08

The Arkansas Medicaid Program covers two medical visits per state fiscal year (July 1 through June 30) for medical services provided by a podiatrist in an office, a beneficiary's home or in a nursing facility for eligible beneficiaries age 21 and over. Benefit extensions may be granted in cases of documented medical necessity.

Medical visits for individuals under the age of 21 in the Child Health Services (EPSDT) Program do not have a benefit limit.

Surgical services provided by a podiatrist are not included in the two visits per state fiscal year (SFY) benefit limit for individuals age 21 and over.

215.000 Extension of Benefits 10-1-08

Benefit extensions may be requested in the following situations:

A. Extension of Benefits for Medical Visits

Extensions of benefits may be requested for medical visits that exceed the two visits per state fiscal year (SFY) for individuals age 21 and over with documented medical necessity provided along with the request.

B. Extension of Benefits for Laboratory and X-Ray Services

Extension of the benefit limit for laboratory and X-ray services may be granted for individuals age 21 and over when documented to be medically necessary.

NOTE: The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis: Malignant Neoplasm (code range 140.0 through 208.91 and 230.0 through 238.9); HIV Infection, including AIDS (code 042) and renal failure (code range 584 through 586).

221.300 Post-Authorization 10-1-08

Post-authorization will be granted only for emergency procedures and/or retroactively eligible beneficiaries. Requests for emergency procedures must be applied for on the first working day after the procedure has been performed. In cases of retroactive eligibility, AFMC must be contacted for post-authorization within 60 days of the authorization date.

242.100 Procedure Codes 10-1-08

Sections 242.100 through 242.120 list the procedure codes payable to podiatrists. Any special billing or other requirements are described in parts A through F of this section and in sections 242.110 and 242.120.

A. Procedure codes for podiatry services provided in a nursing home or skilled nursing facility are listed in section 242.110.

B. Procedure codes 20974 and 20975 for podiatry services require prior authorization. To request prior authorization, providers must contact the Arkansas Foundation for Medical Care, Inc. (AFMC) (see Section 221.000 – 221.100).

C. Procedure codes payable to podiatrists for laboratory and X-ray services are located in section 242.130.

D. Procedure code **99238**, Hospital Discharge Day Management, may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes **99221** through **99233**). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

E. In addition to the CPT codes shown below, **T1015**, a HCPCS code, is payable to podiatrists.

F. Procedure code **99353** must be billed for a service provided in a beneficiary's home.

The listed procedure codes and their descriptions are located in the *Physician's Current Procedural Terminology (CPT)* book. Section III of the Podiatrist Manual contains information on how to purchase a copy of the CPT publication.

Procedure Codes							
J7340*	T1015	10060	10061	10120	10140	10160	10180
11000	11040	11041	11042	11043	11044	11055	11056
11057	11100	11200	11201	11420	11421	11422	11423
11424	11426	11620	11621	11622	11623	11624	11626
11719	11720	11721	11730	11732	11740	11750	11752
11760	11762	12001	12002	12004	12020	12021	12041
12042	12044	13102	13122	13131	13132	13153	13160
14040	14350	15050	15100	15101	15120	15121	15220
15221	15240	15241	15620	15999*	16000	17000	17003
17004	17110	17111	17999*	20000	20005	20200	20205
20206	20220	20225	20240	20500	20501	20520	20525
20550	20551	20552	20553	20600	20605	20612	20615
20650	20670	20680	20690	20692	20693	20694	20900
20910	20974**	20975**	27605	27606	27610	27612	27620
27625	27626	27648	27650	27654	27687	27690	27695
27696	27698	27700	27702	27703	27704	27792	27808
27810	27814	27816	27818	27822	27823	27840	27842
27846	27848	27860	27870	27888	27889	28001	28002
28003	28005	28008	28010	28011	28020	28022	28024
28035	28043	28045	28046	28050	28052	28054	28060
28062	28070	28072	28080	28086	28088	28090	28092
28100	28102	28103	28104	28106	28107	28108	28110
28111	28112	28113	28114	28116	28118	28119	28120
28122	28124	28126	28130	28140	28150	28153	28160
28171	28173	28175	28190	28192	28193	28200	28202
28208	28210	28220	28222	28225	28226	28230	28232
28234	28238	28240	28250	28260	28261	28262	28264
28270	28272	28280	28285	28286	28288	28290	28292
28293	28294	28296	28297	28298	28299	28300	28302
28304	28305	28306	28307	28308	28310	28312	28313
28315	28320	28322	28340	28341	28344	28345	28360

Procedure Codes							
28400	28405	28406	28415	28420	28430	28435	28436
28445	28450	28455	28456	28465	28470	28475	28476
28485	28490	28495	28496	28505	28510	28515	28525
28530	28540	28545	28546	28555	28570	28575	28576
28585	28600	28605	28606	28615	28630	28635	28645
28660	28665	28666	28675	28705	28715	28725	28730
28735	28737	28740	28750	28755	28760	28800	28805
28810	28820	28825	28899*	29345	29355	29358	29365
29405	29425	29435	29440	29445	29450	29505	29515
29520	29540	29550	29580	29750	29893	29894	29895
29897	29898	29899	29904	29905	29906	29907	29999*
36591	36592	64450	64550	64704	64782	73592	73600
73610	73615	73620	73630	73650	73660	82962	87070
87101	87102	87106	87184	93922	93923	93924	93925
93926	93930	93931	93965	93970	93971	95831	95851
99201	99202	99203	99204	99205	99211	99212	99213
99214	99215	99221	99222	99223	99231	99232	99233
99238	99241	99242	99243	99244	99245	99251	99252
99253	99254	99255	99281	99282	99283	99284	99341
99342	99343	99347	99348	99349	99353		

*Procedure codes **15999**, **17999, 28899**, **29999**, and **J7340** are manually priced and require an operative report attached to a paper claim.

** Procedure codes 20974 and 20975 require prior authorization. See Section 221.000 for detailed instructions.

242.410 Completion of Forms for Medicare/Medicaid Deductible and Coinsurance 10-1-08

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed and payment determination finalized prior to billing Medicaid. Medicaid will also cover coinsurance, co-payment and deductible amounts for dually eligible beneficiaries, less any Medicaid cost-share amounts, when applicable. See Sections 332.000 through 332.300 of this manual for detailed information regarding Medicare/Medicaid crossover claim filing procedures and follow-up.