Podiatry

Provider Manual
Volume II

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New Hampshire
Medicaid

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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual – Volume I and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit. See the Appendix for specific contact information.

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Each participating podiatrist shall:

- Be licensed in the state in which he or she practices;
- Be a New Hampshire enrolled Medicaid provider; and
- Adhere to billing guidelines contained in the General Billing Manual – Volume I and those detailed in this Provider Specific Billing Manual – Volume II.

3. Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit theserequests can be found in this Provider Specific Billing Manual - Volume II.

Podiatry services may be provided in the podiatrist's office, the member's home, hospital outpatient facilities, or nursing facilities.

The following podiatry services shall be covered only if they are medical or surgical treatments of the human foot:

(1) Routine foot care, and trimming and burring of nails, including mycotic nails, provided that:

a) The member's primary health care provider has documented in the member's medical record that the member's current medical condition justifies the need for such foot care to be performed by a podiatrist;

b) The member's primary health care provider has written a referral to a podiatrist for such care, documenting in the member's medical record that the referral was made; and

c) The referral is documented as received by, and is retained by, the podiatrist in the member's medical record.

(2) Prevention and reduction of corns, calluses, and warts shall be covered by cutting or surgical means only.

(3) Casting, strapping, and taping are covered services when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains and open wounds of the ankle, foot and toes.

The above treatments are also covered for the lower leg, if related to localized illness, injury, or symptoms involving the foot.

Covered podiatry services also include the following:

(1) Evaluation and management (E&M) codes to include office visits, hospital visits, nursing facility visits and consultations provided to new or established patients in order to evaluate the need for podiatry services and medical treatment.

(2) Surgical procedures consist of cutting procedures, to the foot and lower leg, for the treatment of illnesses and injuries, treatment of fractures and dislocations, treatment of burns, and invasive diagnostic and treatment services. Reimbursement for the surgical procedure is inclusive of the

preoperative visits, casting at the time of the surgery, and postoperative follow up care for up to 30 days following surgery, including office visits and medical supplies.

3.1 Service Limits

Podiatry services are limited to 4 visits per member per state fiscal year (July 1- June 30). More than 1 service (procedure code) may be provided during the course of a visit. A visit means all podiatry services provided to a member on one day by one podiatrist.

3.2 Laboratory Services Ordered by the Podiatrist

Claims for laboratory services must be submitted by the provider of the laboratory services. Payment will be in accordance with fee allowances established by the Department. Automated tests will not be paid for as individual tests broken out of an automated laboratory report. The fee for the automated procedure will be paid as listed. For specimens taken by a podiatrist and sent to an outside laboratory, an allowance will be made to the podiatrist for securing and handling the specimen. This must be coded under 99000 in Field 24D on the CMS 1500. This code number can be used only once per day, per member unless specimens are sent to two separate labs.

3.3 Radiology

Complete x-ray procedures, which include both the professional and technical component(s), do not require a modifier with the procedure code. Podiatrists shall bill for providing either the professional component(s) or the technical component(s) **only**. An adjustment will be required if a bill is submitted for both components.

When billing for the professional component(s) only (supervision, interpretation, and written report) the podiatrist must use modifier 26 next to the appropriate procedure code in field 24D on the CMS 1500 claim form. When billing the technical component(s) only (taking the film), the podiatrist must use modifier TC next to the appropriate procedure code in field 24D on the CMS 1500 claim form.

Radiology services are subject to the service limits described in the Radiology Billing Manual – Volume II.

3.4 Injections

If a beneficiary is given an injection for any purpose during an office visit for podiatry services, the administration is considered to be part of the professional service. Refer to the "Payment Policy" section for additional information.

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid and that should the member still choose to receive the service, then the member is responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

The following podiatry services are not covered:

- Routine foot care, and trimming and burring of nails, except as described under "Covered Services" above;
- Prevention and reduction of corns, calluses, and warts other than by cutting or surgical means only;
- Nail care not involving surgery, except as specified in "Covered Services" above;
- Any podiatry service performed in the absence of pathological conditions of the foot due to localized illness, injury or symptoms involving the foot; and
- Office visits occurring on the same date of service as a podiatry surgical procedure, except where additional non-podiatry related medical conditions are addressed.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The contact information in the Appendices of the General Billing Manual – Volume I or on the SA form itself should be consulted for the name and method of contact.

Podiatry services do not require a service authorization unless services are requested in excess of the service limits (see the General Billing Manual – Volume I).

6. Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I, for more detailed documentation requirements.

In accordance with He-W 532, podiatrists shall maintain the following documentation in the member's podiatry medical record:

- Supporting clinical records;
- Specific written documentation justifying the need for covered podiatry care as described under covered services;
- Specific written documentation, by the podiatrist, specifying the frequency of the podiatry service(s) being performed;
- Specific written documentation of all podiatry services performed; and
- A completed member medical history maintained in the recipient's podiatry medical record.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations, CMS transmittals, provider fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume I.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in the Medicare/Third party Insurance Coverage Section of the General Billing Manual – Volume I.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Payment for services to podiatrists shall be made in accordance with fee schedules established by the Department pursuant to RSA 161:4, VI(a).

Special Considerations

- For physicians or podiatrists who act as surgical assistants during operations for which an assistant is required, the assistant's fee will be paid up to 20% of the surgical allowance.
- If more than one surgical procedure is performed during the same operation through only one route of access and/or the same body system, then payment will be made for only the primary procedure. The primary procedure will be considered the procedure with the highest charge.
- Multiple surgical procedures performed for the same member on the same date of service must be submitted on the same claim form. Podiatrists are reimbursed for multiple surgeries as follows:
    - The first procedure listed on the claim is paid at 100% of the Medicaid allowed amount;
    - The second procedure is paid at 50% of the Medicaid allowed amount; and
    - Each additional procedure is paid at 25% of the Medicaid allowed amount.
- No allowance will be made for topical anesthesia, local infiltration or digital block administered by the operating surgeon. When regional block or general anesthesia is provided by the surgeon, the base anesthesia value without added value for the time will be allowed.
- If a beneficiary is given an injection for any purpose during an office visit for podiatry services, the administration is considered to be part of the professional service. An allowance will be made for the cost of the injected material if applicable.

Incidental Procedures

An incidental procedure is a procedure that is performed at the same time as a more comprehensive procedure. The incidental procedure does not add significant additional work to the provider and/or is integral to the work of the comprehensive procedure. A code that is determined to be incidental will not be eligible for separate reimbursement and will be denied as included in the allowance for the comprehensive procedure.

Preoperative and postoperative follow up care up to 30 days following surgery, including office visits and medical supplies, are included as part of the reimbursement for the surgical procedure.

11. Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, NH Medicaid requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.2 Service Authorizations (SA)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, the NH Medicaid Program does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

11.3 Claim Completion Requirements for Podiatry Services

Podiatry providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P. Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

12. Terminology

Current procedural terminology (CPT) code means a unique identifying code in the field of medical nomenclature and designated by the United States Department of Health and Human Services as the national coding standard utilized in government and private health insurance programs for reporting medical services and procedures.

Department (DHHS) means the New Hampshire department of health and human services.

Medicaid means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

Mycotic nail means a fungus infection of a toenail.

Pathological condition means any disease, trauma, tumors, or deformities affecting anatomy or physiology.

Podiatry service means the diagnosis and treatment of ailments of the human foot and lower leg by any medical, mechanical, electrical, and surgical means available and performed by a podiatrist.

Recipient means any individual who is eligible for and receiving medical assistance under the Medicaid program.

Routine foot care means preventive and hygienic maintenance of the feet, of the type which is ordinarily considered self-care, including observation and cleansing of the feet, and the use of skin creams to maintain skin tone.

State fiscal year means July 1 through June 30.

Title XIX means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

Title XXI means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

Visit means all podiatry services provided to a recipient on one day by one podiatrist.