



# **PODIATRY SERVICES COVERAGE AND LIMITATIONS HANDBOOK**

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**Agency for Health Care Administration**





CHARLIE CRIST  
GOVERNOR

*Better Health Care for all Floridians*

THOMAS W. ARNOLD  
SECRETARY

April 21, 2010

Dear Medicaid Podiatry Services Provider:

The Florida Medicaid Podiatry Services Coverage and Limitations Handbook, January 2010 (Rule 59G-4.220), is amended to implement changes to the handbook that include:

- Changes in fiscal agent references
- Deleted text regarding locum tenens providers
- Added definitions
- Clarified policy particularly regarding place of service to mirror that of optometric services and creating a bulleted list for ease of reading
- Clarified mobile unit limitation
- Deleted language regarding Average Wholesale Price for injection medication
- Discontinued the listing of procedure codes in handbook text

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are listed on the AHCA's website at <http://ahca.myflorida.com>. All the Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder, Chief  
Bureau of Medicaid Services





# UPDATE LOG

## PODIATRY SERVICES

### COVERAGE AND LIMITATIONS HANDBOOK

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#### ***How to Use the Update Log***

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#### **Introduction**

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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#### **Explanation of the Update Log**

Providers can use the update log to determine if they have received all the updates to the handbook.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

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#### **Instructions**

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

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<b>UPDATE NO.</b>	<b>EFFECTIVE DATE</b>
Jan2000—Revised Handbook	January 2000
Jan2001—Revised Handbook	January 2001
Update 02-1—Replacement Pages	January 2002
Update 02-2—Replacement Pages	April 2002
Update 03-1—Replacement Pages	March 2003
Jan2004—Revised Handbook	January 2004
Jan2005—Remove Appendix A	January 2005
January 2010 – Revised Handbook	January 2010



# PODIATRY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### **Overview**

#### **Introduction**

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

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#### **Background**

There are three types of Florida Medicaid handbooks:

- Provider General Handbook—describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks—explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks—describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

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#### **Legal Authority**

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Chapter 59G, Florida Administrative Code

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

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#### **In This Chapter**

This chapter contains:

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**Handbook Use and Format**

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<b>Purpose</b>	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.</p>
<b>Provider</b>	<p>The term “provider” is used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
<b>Recipient</b>	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
<b>General Handbook</b>	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
<b>Coverage and Limitations Handbook</b>	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
<b>Reimbursement Handbook</b>	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
<b>Chapter Numbers</b>	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
<b>Page Numbers</b>	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
<b>White Space</b>	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

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### ***Characteristics of the Handbook***

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**Format** The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

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**Information Block** Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

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**Label** Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

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**Note** Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

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**Topic Roster** Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

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### ***Handbook Updates***

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**Update Log** The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

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**Handbook Updates**, continued

**How Changes Are Updated**

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

**Numbering Update Pages**

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

**Effective Date of New Material**

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

**Identifying New Information**

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

**New Label**

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

**New Label and New Information Block**

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

**New Material in an Existing Information Block**

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

**New or Changed Paragraph**

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

# CHAPTER 1

## PODIATRY SERVICES

### PROVIDER QUALIFICATIONS AND ENROLLMENT

**Overview**

**Introduction**

This chapter describes the general program requirements, the provider enrollment criteria, provider qualifications, and provider requirements.

**Legal Authority**

The federal authority governing the provisions, requirements, benefits, and service payment of the Podiatry Services Program is Title 42, Code of Federal Regulations (C.F.R.), Parts 440.60, 440.230, and 447.304.

The state authority for the licensing of the podiatric physician providers is Chapter 461, Florida Statutes (F.S.).

The Florida Medicaid Podiatry Services Program is authorized by Chapter 409.919, F.S., and Chapter 59G, Florida Administrative Code (F.A.C.).

**In This Chapter**

This chapter contains:

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## ***Purpose and Definition***

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### **Purpose of This Handbook**

This handbook is intended for use by podiatrists who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains the specific procedures for submitting claims for payment.

Note: The handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C., and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

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### **Podiatrist Definition**

Doctors of podiatric medicine are eligible to enroll and participate as podiatrists in the Medicaid Program.

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### **Resident Definition**

A resident podiatric physician has earned the D.P.M. degree and is engaged in a Council on Podiatric Medical Education of the American Podiatric Medical Association approved program of graduate podiatric medical education designed to increase the podiatrist's knowledge of the clinical disciplines of medicine, surgery, orthopedics, or any other special fields which provide advanced training.

Podiatric residents are described as medical school graduates during the first 1 to 3 (PGY1-PGY3) years post-graduation, as applicable.

Note: See Provider Requirements in this chapter for requirements, limitations and exclusions for residents in teaching hospitals.

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## ***Provider Qualifications***

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### **Podiatrist Qualifications**

To enroll as a Medicaid provider, a podiatrist must be licensed as one of the following:

- Podiatric physician within the scope of the practice as defined in Chapter 461 F.S.; or
- Podiatric physician licensed in the state in which the service is provided.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for information regarding out-of-state providers and services.

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**Provider Qualifications**, continued

**Members of the Public Health Service and Armed Forces**

Podiatrists who perform services in Florida, but are not licensed in Florida, may enroll as Medicaid providers if they are commissioned medical officers of the Public Health Service or Armed Forces of the United States, on active duty, and are acting within the scope of their public health service or military responsibilities.

**CLIA Certification and Licensure**

Podiatrists who perform laboratory tests in their offices must be certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and have a current state of Florida clinical laboratory license.

Separate laboratory facilities require separate CLIA certifications and state licenses even if they are operated under the same management.

**Operational at Time of Enrollment**

Podiatrists must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

**Provider Enrollment**

**General Enrollment Requirements**

Podiatrists must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, podiatrists must follow the specific enrollment requirements that are listed in this section.

**Group Providers**

When two or more providers bill Medicaid using the same tax identification number, they must enroll in Medicaid as a group. Each member in the group who bills Medicaid must also enroll as an individual Medicaid provider. The providers are not required to practice at the same location to enroll as a group. However, group providers must obtain a location code provider number for each location where they have a physical office.

The group number is used for billing and tax identification purposes only.

**Provider Enrollment**, continued**Multiple Locations**

Individual or group providers who render services at more than one physical location under a single license or certification are required to submit an Application for New Location Code to identify each location where they have a physical office. This is required for each type of service for which the provider is enrolled.

The provider must notify the Medicaid fiscal agent of additional practice locations where they intend to serve Medicaid recipients prior to providing the services at the new location. Notification must be made in writing on an Application for a New Location code and must include an effective date for the new location.

The provider must be assigned a separate Medicaid provider identification number for each physical location by the Medicaid fiscal agent. The provider must cross-reference its National Provider Identifier to its locations' Medicaid provider numbers using taxonomy or zip code plus four as identifiers. Any closure or intended closure of a practice location must also be reported immediately to the Medicaid fiscal agent, in writing on office letterhead stationery, along with the effective or intended date of closure.

Note: An Application for New Location Code may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799 and selecting Option 4 or from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Enrollment. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003.

Note: See Chapter 2 in the Provider General Handbook for additional information on group providers, multiple locations, and reporting changes.

**Provider Enrollment**, continued

**Other Licensed Health Care Practitioners, Working Within a Podiatry Practice**

If a podiatric provider employs or contracts with a non-podiatric physician health care practitioner who can enroll as a Medicaid provider, and that health care provider is treating Medicaid recipients, the practitioner must enroll as a Medicaid provider.

Examples of non-podiatric physician health care practitioners who can enroll as Medicaid providers are: physician assistants, advanced registered nurse practitioners, registered nurse first assistants, physical therapists, etc.

If the services rendered by a non-podiatric physician health care practitioner are billed with that practitioner as the treating provider, the services must be provided in accordance with the policies and limitations contained in that practitioner's service-specific Florida Medicaid Coverage and Limitations Handbook.

Note: All Medicaid Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks. The Coverage and Limitations Handbooks are incorporated by reference in the service-specific rules in 59G-4, F.A.C.

**Individual Provider Responsibilities Within a Group Practice**

An individual treating provider must be enrolled as a member of group practices for which he performs services. The individual treating provider is responsible for notifying the Medicaid fiscal agent of all group practices with which he is affiliated.

Any individual treating provider who is terminating his relationship with a group practice must notify the Medicaid fiscal agent in writing of this termination in order to alter the provider file.

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**Provider Requirements**

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**General Requirements**

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, podiatric physician providers are also responsible for complying with the provisions contained in this section.

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**Provider Responsibility**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

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**Podiatrist Supervision**

Delivery of all podiatric services must be done by, or under the direct supervision of, the podiatrist.

Direct supervision means the podiatrist:

- Is on the premises when the services are rendered; and
  - Reviews, signs and dates the medical record.
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**Teaching Podiatrists**

Teaching podiatrists who seek reimbursement for oversight of patient care by a resident must directly supervise, as defined above, all services performed by the resident.

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**Provider Requirements**, continued**Residents in Teaching Facilities**


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Residents whose salaries are considered in the hospital's cost report may not bill Medicaid on a fee-for-service basis. If the hospital has elected not to report residents' salaries in its cost report, the residents may bill Medicaid directly on a fee-for-service basis.

All federal laws, Florida Statutes, and Florida Administrative Code Rules applicable to the Florida Medicaid Program apply to residency programs.

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**Students in Clinical Teaching Institutions**

Students in Florida medical teaching hospitals may document in the medical record and participate in key components of a billable service. The medical record entry must be dated and cosigned by the billing podiatric physician.

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**Podiatrists Employed by Facilities**

A podiatric physician who is salaried by a facility that is reimbursed by Medicaid on a cost-related basis may not be reimbursed directly on a fee-for-service basis if the cost for the podiatric physician's salary is included in the facility's cost report.

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**Rural Health Clinic or Federally Qualified Health Center**

Podiatric physician providers enrolled under the group number of a rural health clinics (RHC) or federally qualified health centers (FQHC) and who provide services in the RHC or FQHC must bill all the services they provide in accordance with policies outlined in the RHC or FQHC Coverage and Limitations Handbooks.

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**Requirement for Medical Records**

See Chapter 2 in the Florida Medicaid Provider General Handbook for record keeping requirements.

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## **Mobile Podiatry Units**

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### **Description**

A mobile podiatry unit is a fully operational podiatry vehicle, unit, or trailer that travels to different locations for the provision of podiatry services and is not a stationary podiatry unit.

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### **Limitations and Exceptions**

Mobile podiatry unit providers may only contract with County Health Departments (CHDs) or Federally Qualified Health Centers (FQHCs). Rural Health Clinic (RHC) mobile units must be certified by Medicare as mobile RHCs in accordance with the Code of Federal Regulations, Title 42. Medicaid will only reimburse CHDs, FQHCs, and RHCs for mobile unit podiatry services.

Mobile unit podiatry services must be provided and billed in compliance with this handbook and the applicable Florida Medicaid County Health Department Clinic Services, Federally Qualified Health Center, or Rural Health Clinic Coverage and Limitations Handbook.

All podiatry services furnished in a mobile unit must be billed using the group identification number of the CHD, RHC or FQHC. Mobile unit podiatry services that do not meet contract or certification requirements specified above are not eligible to provide podiatry services.

Note: The Florida Medicaid CHD, FQHC or RHC Coverage and Limitations Handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The County Health Department Clinic Services Coverage and Limitations Handbook is incorporated by reference in 59G-4.055, F.A.C. The Rural Health Clinic Coverage and Limitations Handbook is incorporated by reference in 59G-4.280, F.A.C. The Federally Qualified Health Center Coverage and Limitations Handbook is incorporated by reference in 59G-4.100, F.A.C.

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## CHAPTER 2

### PODIATRY SERVICES

#### COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

#### **Overview**

#### **Introduction**

This chapter describes the services covered under the Florida Medicaid Podiatry Services Program. It also describes limited or excluded services.

#### **In This Chapter**

This chapter contains:

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#### ***General Service Requirements, Limitations and Exclusions***

#### **Definition**

Podiatry is “the specialty concerned with the diagnosis and or the medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot.” Podiatry services may include routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds and infections.

#### **Podiatry Services**

Medicaid will reimburse podiatrists for medically necessary and reasonable treatment of injuries and diseases of the feet.

Foot care, for recipients with medically documented underlying systemic conditions affecting the lower limbs, is also a covered service.

**General Service Requirements, Limitations and Exclusions**, continued

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**Covered Services**

Only the services designated in this chapter and listed in the Podiatry Services Fee Schedule are covered services.

Note: The Podiatry Services Fee Schedule is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, then Provider Support, and Fee Schedules.

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**Excluded Services**

The following services are **not covered** under the Medicaid Podiatry Services Program:

- Podiatry services rendered in a place of service that do not meet the criteria described in the Place of Service and Exception to Place of Service sections of this chapter;
  - Treatment of flat foot conditions;
  - Cosmetic surgery;
  - Experimental or clinically unproven surgeries or treatments; and
  - Surgical or non-surgical treatment for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.
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**Limitations**

Certain services are designated with limitations by diagnosis or other limitations in the Podiatry Services Fee Schedule. Other limitations specified in this handbook also apply.

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**General Service Requirements, Limitations and Exclusions**, continued**Medically Necessary**

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Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

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**Duplicate Services**

Medicaid will not reimburse a podiatrist and the following provider types for the same procedure, same recipient, and same date of service:

- Advanced registered nurse practitioner
  - Chiropractor
  - County health department
  - Federally qualified health center
  - Licensed midwife
  - Physician
  - Physician assistant
  - Registered nurse first assistant
  - Rural health clinic
  - Schools
-

**General Service Requirements, Limitations and Exclusions**, continued

**Service Limitations**

Medicaid will reimburse only one visit per podiatrist or podiatrist group, per recipient, per day, except for emergency services.

Certain procedure codes have service frequency and diagnosis limitations based upon utilization control measures.

**Professional Component Fee**

For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a professional component (PC) fee.

Note: See Place of Service and Exception to Place of Service sections in this chapter.

**Maximum Fee**

The maximum fee is intended to pay the podiatrist for performing the complete procedure, including both the technical and professional components. The maximum fee, included in the Podiatry Fee Schedule, can be billed only when the same provider performs all components.

Note: See Chapter 3 of this handbook for additional information regarding the Podiatry Services Fee Schedule.

**MediPass Authorization**

If the recipient's managed care option is MediPass, the recipient's MediPass primary care provider does not need to authorize the first four (4) visits to a podiatrist, per calendar year. Subsequent podiatry visits must be authorized by the MediPass primary care provider (PMP). The subsequent claims must include the authorization number provided by the recipient's MediPass PMP.

Note: See Chapters 1 and 3 in the Florida Medicaid Provider General Handbook for information regarding MediPass requirements.

**Place of Service**

Podiatry services may be provided only in the following places of service:

- Ambulatory surgical center
- Podiatrist's office
- Emergency room
- Federally qualified health center
- Rural health clinic
- Hospital

A place of service code that accurately describes where the service was rendered must be included on the claim for reimbursement.

**General Service Requirements, Limitations and Exclusions**, continued**Exception to Place of Service**

Podiatry visits may be rendered in a recipient's place of residence when all of the following criteria are met:

- The recipient's primary care physician has signed and dated an order for specific and medically necessary podiatric services;
- The recipient has been provided an opportunity to select his podiatric services provider from enrolled local providers;
- Podiatry services rendered in the residential facility or in the recipient's personal home are qualitatively comparable to the same podiatry service(s), when rendered in a location listed in the Place of Service section of this chapter;
- Ambulance or stretcher van services are required to transport the recipient to one of the service locations described in the Place of Service section of this chapter;
- A dated and signed statement from the recipient's primary care physician attests that moving the recipient from his residential facility will cause an unacceptable health risk, due to the recipient's current frail health or medical condition; and
- The medical need for the exception to place of service must be ordered by the recipient's primary care physician;
  - The physician's order (documentation of medical necessity) is valid up to 90 days after the order is signed and dated by the referring physician.
  - If additional podiatry services are required, the medical necessity of the additional service must be determined by the recipient's primary care physician.

Pursuant to Chapter 59A-4. 107, F.A.C., verbal treatment orders shall be countersigned by the primary care physician on the next visit to the facility and must be filed in the recipient's medical record at both the facility and the podiatry service provider's office.

For podiatry services provided in the recipient's home, documentation of medical necessity described above and documentation of services rendered must be maintained in the recipient's medical record in the provider's office. For podiatry services provided in the recipient's residential facility, the documentation of medical necessity and documentation of services rendered must be maintained in the recipient's medical record in the both the facility and in the provider's office.

Podiatry services rendered in the recipient's home or in the recipient's residential facility cannot be billed with a place of service code(s) assigned to any of the locations described in the Place of Service section of this chapter.

A recipient's place of residence includes: 1) the recipient's home, 2) the recipient's nursing home, 3) an intermediate care facility for the developmentally disabled (ICF/DD), or 4) a custodial care facility.

Note: See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions.

**General Service Requirements, Limitations and Exclusions, continued**

**Exception to Place of Service, continued**

Transportation services are included in the per diem rate of an ICF/DD. See the Florida Medicaid ICF/DD Services Coverage and Limitations Handbook.

Note: The Florida Medicaid ICF/DD Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

**Illegal Remuneration**

Providers may not offer, pay, solicit, or receive any remuneration in violation of 42 U.S.C. 1320a-7b.

**Consultation Services**

**Description**

A consultation visit is a face-to-face evaluation provided by a podiatrist whose opinion or advice regarding evaluation or management of a recipient's specific problem is requested by another podiatrist or primary care provider.

Consultation services may be rendered in an inpatient, outpatient, or office setting.

A consultation initiated by a recipient or the recipient's family or the recipient's caregiver and not requested by another health care provider cannot be claimed for reimbursement as a consultation visit. The visit is instead considered an office visit.

**Consultation that Becomes a Referral**

If subsequent to the completion of a consultation the provider assumes responsibility for management of a portion or all of the recipient's care, the provider may not bill for the follow-up consultation codes as defined by the Physicians' Current Procedural Terminology (CPT) book.

In the hospital setting, the podiatrist receiving the recipient for partial or complete transfer of care must use the appropriate inpatient hospital consultation code for the initial encounter and then subsequent hospital care codes.

In the office setting, the appropriate established patient evaluation and management code must be used.

**Consultation Services**, continued**Documentation Requirements**

At a minimum, the following information must be documented and maintained in the recipient's medical record in the consultant's office:

- A referral for consultation, obtained from the recipient's attending physician or requesting podiatrist, that includes a statement of medical need for consult;
- Consultant's post-consult visit opinion and description of services, if any, ordered or performed;
- Diagnostic testing results;
- Consultant's written report to the attending physician or requesting podiatrist; and
- All additional referral information.

The referring physician or podiatrist's name and Medicaid ID Number or National Provider Identifier (NPI) must be included on the claim for reimbursement.

Note: See Chapter 1 of the Provider Reimbursement Handbook, CMS-1500, for information regarding entering the referring provider's Medicaid Provider ID or NPI on the claim. Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

**Hospital Inpatient Consultation Visit Limitations**

Medicaid reimbursement is limited to one initial consultation per hospitalization, per recipient, per podiatrist.

If a partial or complete transfer of care occurs following the initial hospital consultation, all follow-up visits are considered subsequent hospital visits.

Only when requested by the attending podiatrist to obtain a management modification or advice on a new plan of care in response to changes in the recipient's status will Medicaid reimburse for a follow-up inpatient consultation. This request must be documented and maintained in the recipient's medical record at the hospital and at the consultant's office.

**Office or Hospital Outpatient Consultation Visit Limitation**

Medicaid reimbursement is limited to one initial consultation visit per podiatrist, per 365 days, for a non-hospitalized recipient.

If a partial or complete transfer of care occurs following the initial office or outpatient consultation visit, all follow-up visits are considered subsequent evaluation and management services.

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending podiatrist, an evaluation and management visit code must be billed.

**Consultation Services**, continued

**Consultation Visits for MediPass Recipients**

If a patient is a MediPass recipient, the consulting podiatrist must obtain a referral number from the MediPass primary care provider (PCP) and must enter the MediPass referral number on the claim for payment, after the recipient has used his first 4 visits.

Note: See Chapters 1 and 3 in the Florida Medicaid Provider General Handbook for additional information regarding MediPass, and the Provider Reimbursement Handbook, CMS-1500, regarding claim form instructions.

**Non-reimbursable Consultation Visits**

Medicaid does **not** provide reimbursement for the following:

- Consultations for a second opinion;
- Consultation on a decision for surgery; or
- Consultations and surgical procedures rendered on the same day.

Medicaid does **not** reimburse a consultation visit in addition to:

- An office visit;
- A home visit;
- A nursing facility visit;
- A custodial care facility visit;
- An in-patient hospital visit; or
- An outpatient hospital visit claimed on the same day of service, by the same provider.

Medicaid also does not provide reimbursement for consultation visits rendered in nursing or custodial care facilities.

**Procedure Codes and Fees**

The Podiatry Fee Schedule includes covered procedure codes, a code description and associated fees.

Note: All Medicaid Fee Schedules are available on the Medicaid fiscal agent Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**Injectable Medication Services**


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**Definition**

Injectable medication is defined as a drug or vaccine that can be introduced into a body part, especially by means of a syringe.

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**Description**

Injectable medication services allow podiatrists to claim reimbursement for the injection of medications approved by the Food and Drug Administration (FDA).

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**Procedure Code**

Injectable medications are reimbursed by billing the appropriate J, Q, S or HCPCS code, when a provider of podiatry services purchases and administers the medication in his office.

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**Non-FDA Approved Medications**

Medicaid does not provide reimbursement for non-FDA approved medications. Medicaid does not reimburse for the rendering of experimental procedures or for any procedures that include the use of non-FDA approved medications.

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**Evaluation and Management Services**

Injectable medications covered by Medicaid are reimbursable, in addition to an evaluation and management (E&M) service when the visit is for a separate and identifiable service and the documentation for service is maintained in the recipient's medical record.

Note: See Reimbursement Rate section in this chapter.

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**Reimbursement Rate**

Medicaid reimburses for injectable medications based on the Medicaid Prescribed Drug Program's reimbursement methodology.

All claims for injectable medications must include the National Drug Code (NDC) information, as required by the Provider Reimbursement Handbook, CMS-1500.

Note: See Chapter Two of the Prescription Drug Services Coverage and Limitations Handbook for reimbursement methodology. Medicaid handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Note: See Chapter 1 of the Provider Reimbursement Handbook, CMS-1500, for required NDC information.

Note: See the Podiatry Services Fee Schedule for covered procedure codes, code descriptions, and associated fees. Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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<b>Laboratory Services</b>	
<b>Description</b>	Laboratory services reimbursed under Medicaid's Podiatry Services are limited to those procedure code(s) included on the Podiatry Services Fee Schedule.
<b>CLIA Certification and Licensure</b>	<p>Podiatrists who perform laboratory tests in their office must be certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and must maintain a current state of Florida clinical laboratory license on site.</p> <p>Individual podiatry office locations with laboratory facilities require separate and individual CLIA certifications and state licenses for each physical location, even if the individual offices operate under the same management and use the same FEIN.</p>
<b>Covered Laboratory Services</b>	Laboratory services covered by Medicaid's Podiatry Services include the microscopic analysis of cultured specimens collected and tested for fungi.
<b>Maximum Fee</b>	<p>To receive the maximum fee for laboratory services provided in a podiatrist's office, the service must include both the technical and professional components. These components include:</p> <ul style="list-style-type: none"> <li>• Performing the service; and</li> <li>• Interpreting the results.</li> </ul>
<b>Independent Lab</b>	<p>A freestanding or independent laboratory facility is described as a licensed facility that is not controlled, managed or supervised by:</p> <ul style="list-style-type: none"> <li>• A hospital or a hospital's organized medical staff; or</li> <li>• The treating health care practitioner.</li> </ul> <p>Laboratory services for specimens routed to an independent laboratory are reimbursed directly to the independent laboratory, and cannot be claimed for reimbursement by the podiatrist.</p> <p><u>Note:</u> See the Podiatry Services Fee Schedule for covered lab codes.</p>
<b>Specimen Collection</b>	The collection and handling of specimens is included in the reimbursement for the visit and cannot be billed separately.
<b>Procedure Codes and Fees</b>	See the Podiatry Services Fee Schedule for a list and description of procedure codes and fees. Medicaid Fee Schedules are available on the Medicaid Web Portal at <a href="http://mymedicaid-florida.com">http://mymedicaid-florida.com</a> . Select Public Information for Providers, Provider Support, and Fee Schedules.

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**Podiatry Visit Services**


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**Description**

Podiatry visit services are face-to-face podiatrist and recipient encounters.

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**New Patient Visit**

One new patient visit may be reimbursed once per recipient, per provider or provider group.

A new patient is one who has not received any professional services from the provider or provider group within the past three years.

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**Established Patient Visit**

An established patient is one who has received professional services from the provider or provider group within the last three years.

---

**Definition of a Visit**

A visit means a face-to-face, podiatrist-to-recipient contact that is reimbursed as an all-inclusive fee for all the services provided the recipient at the time of the visit. Examples of services are: therapeutic injections, dressings, surgical trays, handling of laboratory specimens, and x-rays when the recipient is being referred to another provider for services.

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**Office Visits**

Office visits may be reimbursed for services provided in a podiatrist's office, an outpatient facility, or ambulatory facility.

Reimbursement is limited to two visits per recipient a month, per provider or group provider. The two visits cannot be claimed for the same day.

Note: See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions.

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**Home Visits**

Medically necessary home visits may be reimbursed when the podiatrist completes the visit in the private residence of the recipient.

Reimbursement is limited to two visits per recipient a month, per provider or group provider. The two visits cannot be on the same day.

Visits must be documented and maintained in the recipient's individual medical record at the provider's office. A home visit cannot be billed with place of service code 11.

Note: See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions.

Note: Refer to Place of Service and Exception to Place of Service section of this Chapter.

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**Podiatry Visit Services**, continued**Custodial Care  
and Nursing  
Facility Visits**

Medically necessary podiatry services may be reimbursed when the podiatrist completes the visit in a nursing facility, assisted living facility, intermediate care facility for the developmentally disabled (ICF/DD), and other custodial care facilities.

Visits performed in these locations are limited to one visit a month, per recipient, per provider or provider group. Visits must be documented and maintained in the recipient's individual medical record at both the provider's office and at the recipient's residential facility. A podiatry visit performed in a residential facility cannot be billed with place of service code 11.

Note: See Place of Service under General Service Requirements, Limitations and Exclusions in this chapter.

Note: See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions and information regarding CMS-1500 claim form instructions.

**Hospital Visits**

Hospital visits for an inpatient recipient may be reimbursed when the podiatrist completes:

- A non-surgical service; or
- A modifier 24 or 25 is appropriately added to the visit code.

Hospital visits to a recipient are not reimbursable if the visits are related to a procedure that is not covered by Medicaid. Hospital visits are limited to one visit a day, per recipient, per provider or provider group.

Note: See Chapter 3 of this handbook for additional information regarding the appropriate use of modifiers. See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions and information regarding CMS-1500 claim form instructions.

**Emergency Care  
Visits**

Emergency room visits may be reimbursed when the emergency service is provided in the emergency room of a hospital and the podiatrist's services are not included in the hospital's cost report.

Visits are limited to one visit a day, per recipient, per provider or provider group. An emergency visit is not allowed on the same day as a surgical procedure.

**Podiatry Visit Services**, continued**Visits in Excess of the Service Limitations**

If visits in excess of the service limitation are due to an emergency, the claim **must** include an emergency indicator.

Emergency related documentation must be maintained in the recipient's medical record at the provider's office.

Note: See Chapter 3 in this handbook for additional information regarding modifiers.

**Procedures that May be Reimbursed in Addition to Visits**

Medicaid reimburses certain procedures in addition to a visit on the same date of service. Procedures that may be reimbursed in addition to a visit are identified and described in the current edition of the CPT book.

**Chelation Therapy**

Medicaid only reimburses medically necessary chelation therapy for recipients with known toxic substances. Laboratory documentation of the toxic substance(s) must be maintained in the recipient's medical record.

**Definition of Routine Hygienic Care**

Routine hygienic care means hygienic and preventive maintenance care of the foot that is ordinarily within the realm of self care, that include: observation and cleansing of the feet; use of skin cream to maintain skin tone of both ambulatory and bedfast patients; prevention and reduction of corns and calluses; and any services performed in the absence of localized illness, injury or symptoms involving the feet.

**Definition of Routine Foot Care**

Routine foot care means the cutting or removal of corns and calluses, the trimming of nails, routine hygienic care, and other routine-type care of the foot.

**Routine Foot Care**

Routine foot care may be reimbursed, in addition to an office visit, when the recipient:

- Is under a physician's care for a diagnosed metabolic disease;
- Has diagnosed conditions of circulatory impairment; or
- Has diagnosed conditions of desensitization of the legs or feet.

Documentation, obtained from the recipient's primary care physician (PCP), regarding the recipient's underlying disease or condition must be maintained in the recipient's medical record. The name and identification number of the referring physician must be included on the service provider's claim form.

Note: See Chapter 1 of the Provider Reimbursement Handbook, CMS-1500, for claim form instructions.

**Podiatry Visit Services**, continued

**Debridement of the Toe Nails**

Debridement of the toe nails cannot be reimbursed in addition to a visit code.

**Procedure Codes and Fees**

See the Podiatry Services Fee Schedule for a list and description of procedure codes and fees. Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

**Radiology Services**

**Description**

Medicaid provides reimbursement of Podiatry Services for certain diagnostic radiology services (X-rays).

**Supervision**

Non-invasive radiological studies do not require direct podiatrist supervision to be reimbursed by Medicaid, but do require indirect supervision.

Indirect supervision means that the supervising podiatrist:

- Is not required to be physical presence when the procedure is performed; but
- Must be reasonably available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the recipient.

Invasive radiological studies do require direct podiatrist supervision to be reimbursed by Medicaid.

Direct supervision means the supervising podiatrist must:

- Be on the premises when the services are rendered; and
- Review, sign and date the medical record.

Note: See the Podiatry Services Fee Schedule for covered radiology procedure codes, code descriptions, and associated fees.

**Radiology Services**, continued

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**Maximum Fee**

To be reimbursed the maximum fee for a radiology service, the podiatrist must provide both the technical and professional components.

When a non-invasive radiological study is performed in an office setting, the podiatrist billing the maximum fee must directly or indirectly supervise the technical component of the performed procedure. The provider must directly perform the interpretation and results of the study.

The podiatric members within a group practice must perform both the professional and technical components of the service.

The maximum fee is not reimbursed if the professional component and the technical component are billed separately on the claim form.

Initial evaluation or consultation provided prior to radiation therapy, is claimed as a separate procedure.

---

**Claiming the Professional Component**

A professional component (PC) service is the podiatrist's interpretation and reporting of the radiological exam and is identified by entering modifier 26 in the modifier field on the claim form.

The professional component is not reimbursed separately when a podiatrist or members of a group practice perform both the professional component and technical component.

If the professional service component is provided for an emergency room recipient, use the appropriate code for "outpatient hospital" as the place of service on the claim.

When an X-ray is taken in the emergency room, either the emergency room podiatric physician or a radiologist is reimbursed for the professional component, but not both.

Note: See Chapter 1 of the CMS-1500 Provider Reimbursement Handbook for a list of valid place of service codes and code descriptions.

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**Radiology Services**, continued

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**Claiming the Technical Component**

A technical component service includes the use of provider's equipment, personnel, and supplies in the performance of a radiological exam and is identified by entering a TC modifier in the modifier field on the claim form.

Medicaid only reimburses the radiological technical component for podiatrists rendering the service in the provider's office.

For non-invasive radiology studies, the podiatric physician billing the technical component must either perform or indirectly supervise the performance of the radiological study; or if a group practice, a member of the group must perform or indirectly supervise the radiological study.

For invasive radiology studies, the podiatric physician billing the technical component must perform or directly supervise the performance of the radiological study; or if a group practice, a member of the group must perform or directly supervise the radiological study.

The technical component is not reimbursed if the professional component and technical component are billed separately on the claim form.

---

**Diagnostic Radiology**

Diagnostic radiology includes:

- Limited exam, which includes anterior, posterior and lateral views and is only part of a complete exam; or
- Complete exam, including all necessary views for optimal examination.

All procedures are considered complete unless otherwise indicated. The procedure is performed by the same podiatric physician and includes injection of contrast media.

Note: See Chapter 3 in this handbook for additional information regarding modifiers.

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**Radiology Services**, continued**Computerized Tomography**

To receive Medicaid reimbursement for a computerized tomograph (CT), the primary diagnosis code must be listed in Appendix A, Diagnosis Code List for MRIs and CT Scans.

The maximum fee identified on the Podiatry Services Fee Schedule is the maximum amount allowable for a scan, with or without contrast media.

Reimbursement for follow-up visits on the same day is included in the fee for the scan.

Note: See Appendix A in this handbook for the Diagnosis Code List for MRIs and CT Scans.

**Radiology Frequency**

Only one interpretation per radiology procedure is reimbursable.

**CT Scan Frequency**

There is no allowance for repeat computerized tomography scans on the same day.

No more than two body areas per day or up to three procedures within 30 days can be billed per recipient for computerized tomography scan.

**Service Exclusions**

The following radiology services are excluded:

- Radiology and ultrasound services performed by mobile providers;
- X-rays for soft tissue diagnosis; and
- Magnetic resonance imaging (MRI) and CT scan of the same body part on the same date of service for the same recipient.

**Procedure Codes and Fees**

The Podiatry Services Fee Schedule includes a list of covered procedure codes, code descriptions, and related fees.

Note: Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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## **Surgery Services**

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**Description**

Surgical services are manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases.

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**Global Surgical Package**

The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services.

The preoperative period that is included in the global fee for surgery is the day of surgery—day one.

The postoperative period for major surgery is 90 days and for minor surgery is 0 to 10 days, depending on the procedure.

Separate billing for related post-surgical follow-up care that falls within the designated postoperative days for the performed procedure is not allowed.

---

**Global Surgical Package Components**

The following services are included in the payment amount for a global surgery:

- The preoperative visit on day one (the day of surgery);
- Intraoperative Services—Intraoperative services are a usual and necessary part of a surgical procedure; examples are local anesthetic, digital block, or topical anesthesia;
- Complications Following Surgery—All additional medical or surgical services required of the surgeon during the postoperative period of the surgery, because of complications that do not require additional trips to the operating room;
- Post Surgical Pain Management—By the surgeon;
- Miscellaneous Services and Supplies—Items such as dressing changes; local incisional care; removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes; and
- Postoperative Visits—Follow-up visits within the postoperative period of the surgery and related to recovery from the surgery.

**Note:** See the Podiatry Services Fee Schedule for the number of follow up days included in the surgical fee. Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**Surgery Services**, continued**Global Surgical Package Exclusions**


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The following services are not included in the payment for global surgery:

- Diagnostic tests and procedures, including diagnostic radiological procedures;
  - Treatment for postoperative complications that requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. It does not include a patient's room, a minor treatment room, a post-anesthesia care unit, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR); and
  - Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- 

**Surgical Care Only**

If performing surgical care only, the provider must use modifier 54 when billing the appropriate surgery code.

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**Surgery Authorization**

Surgery that requires prior authorization is identified in the Podiatry Fee Schedule, by "PA" in the "Spec" column.

Only when a surgical procedure requiring prior authorization is performed as an emergency service, is a request for post authorization appropriate. In this circumstance the same documentation submission procedure is used as for a prior authorization request. The request will be identified as a post authorization request and the date of the service must be entered in the appropriate spaces located at the upper portion of the Florida Medicaid Authorization Request form (PA01, July 2008).

Note: Refer to Chapter 2 in to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for prior authorization procedures. The Florida Medicaid Authorization Request form, PA01, July 2008, is available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Forms.

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**Surgery Services**, continued**Child Health Check-Up**


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Surgery for recipients under the age of 21 can be performed without prior authorization if there is documentation, dated within 12 months prior to the surgical procedure, that supports the following:

- The recipient had a Child Health Check-Up (formerly called an EPSDT) screening;
- The recipient was referred for the condition requiring the surgery; and
- The recipient has a MediPass referral, if the recipient is enrolled in MediPass.

A MediPass referral is not valid for any out-of-state services nor is it the same as a prior authorization for surgical services indicated in the podiatry fee schedule as requiring prior authorization.

Note: See Chapters 1 and 3 in the Florida Medicaid Provider General Handbook for additional information regarding MediPass.

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**Pain Management**

Pain management is not reimbursed in addition to a surgical procedure.

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**Unlisted Procedures**

Unlisted procedures or procedure codes ending in 99 must **only** be used when there is no available procedure code on the Podiatry Fee Schedule that describes the service rendered.

All unlisted procedure codes, identified with a “R” under the SPEC column of the Podiatry Fee Schedule, require the provider to submit a report with the claim, that documents the service to be provided for medical consultant review and pricing.

Note: Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**Incidental Procedures**

Incidental surgical procedures are not separately reimbursable services.

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**Assistant Surgeon**

Only one assistant surgeon may be reimbursed per operative session for major surgery. Assistant surgeons cannot be reimbursed for minor surgeries.

Note: See the Podiatry Services Fee Schedule for a list of covered procedure codes, code descriptions, and associated fees.

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**Surgical Trays**

Surgical trays used for office surgery are included in the surgical procedure and must not be claimed separately.

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**Surgery Services**, continued

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**Cosmetic Surgery**

Cosmetic surgery is not reimbursable.

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**Subluxated  
Structure in the  
Foot**

Medicaid does not reimburse for surgical or non-surgical treatment that is performed for the sole purpose of correcting a subluxated structure in the foot as an isolated entity.

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**Procedure Codes  
and Fees**

The Podiatry Services Fee Schedule includes a list of covered procedure codes, the code description, and associated fees. All Medicaid fee schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers Provider Support, and Fee Schedules.

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CHAPTER 3  
PODIATRY SERVICES  
PROCEDURE CODES AND SPECIAL SITUATION CODES

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**Overview**

**Introduction**

This chapter describes the procedure codes, and appropriate modifiers, used for the services reimbursable by Medicaid. These codes must be used appropriately by podiatrists providing services to eligible recipients.

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**In This Chapter**

This chapter contains:

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Reimbursement Information	3-1
How to Read the Podiatry Fee Schedule	3-2
Pricing Modifiers and Their Descriptions	3-5
Appendix A—Diagnosis Code List for MRIs and CT Scans	A-1

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**Reimbursement Information**

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**Procedure Codes**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level 1 and Level 2. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to your current edition of CPT book, for complete descriptions of the standard codes. CPT codes and descriptions are copyrighted by the American Medical Association. All rights reserved.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code. Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

In compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in federal law.

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**Reimbursement Information**, continued

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**Diagnosis Code** A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required, when available.

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**Copayment** Medicaid recipients, unless exempt, are responsible to pay a copayment of \$2.00, per provider or group provider, per day, for podiatry services.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for categories of recipients and provider services that are exempt from the copayment. All Medicaid Handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

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**How to Read the Podiatry Fee Schedule**

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**Introduction** Specific CPT codes are reimbursed by Medicaid to podiatrists. CPT codes reimbursed by Medicaid are listed on the Podiatry Services Fee Schedule.

Note: See the Podiatry Services Fee Schedule for a list of procedure codes, code descriptions, and associated fees. All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**Description** The procedure codes and fee schedule is a table of columns listing CPT procedure codes, code descriptions, and other information pertinent to each code.

The following information explains the fee schedule columns, reading from left to right.

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**Code** The number in this column identifies the procedure being billed.

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***How to Read the Podiatrist Fee Schedule***, continued

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**Code Description**

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to their current CPT or HCPCS Level 2 books for a complete code description, for billing purposes. The CPT and HCPCS Level 2 books include identifying codes and descriptions for reporting medical services and procedures.

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**Age 00-20  
Max Fee**

The fee in this column is the maximum allowable amount Medicaid will pay for the line item procedure, when rendered to Medicaid recipients under the age of 21.

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**21+  
Max Fee**

The fee in this column is the maximum allowable amount Medicaid will pay for the line item procedure when rendered to Medicaid recipients age 21 and older.

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**PC  
Age 00-20**

The fee in this column designates the amount payable for the professional component only of the service, for Medicaid recipients under the age of 21.

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**PC  
Age 21+**

The fee in this column designates the amount payable for the professional component only of the service, for Medicaid recipients age 21 and older.

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**Surgery Follow-  
Up Days (FUD)**

The number in this column designates the number of days following the date of surgery during which podiatrist's visits are included in the surgical fee, and cannot be billed separately.

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**Units**

The number in this column indicates the number of units of service that may be billed on a single claim line.

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**Spec**

An alphabetic code in this column indicates special requirements for submission of a claim for that procedure. Any of the alphabetic codes described below may appear in this column.

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**How to Read the Podiatrist Fee Schedule**, continued

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**AS** Identifies a procedure code that requires billing with a modifier 80 when an assistant surgeon is requesting reimbursement.

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**PA** Identifies a procedure code for which written prior authorization may be granted by the Medicaid office for services to be performed in a setting outside of the inpatient hospital, is required before performing the service.

Note: Refer to Chapter 3 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information regarding the prior authorization process. All Medicaid handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Note: See Exception to Place of Service under the General Service Requirements section in Chapter 2 of this handbook, which describes prior authorization to meet specific service criteria.

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**R** Identifies a procedure code for which documentation of medical necessity for the procedure performed is required or information is needed, for the claim to be reviewed and appropriately priced for reimbursement.

Procedure codes identified on the fee schedule with an “R” require a written report to be submitted with the claim.

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**B** Identifies a procedure code that allows billing as a bilateral procedure, when the procedure code is billed with a modifier 50.

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**LT/RT** Identifies a procedure code that allows billing for either the left or right side of the body, when billing for a radiology or surgical procedure. Use LT or RT on the claim form.

Note: See the Pricing Modifiers and Their Descriptions section in this chapter.

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## **Pricing Modifiers and Their Descriptions**

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### **Modifiers**

This section includes special instructions for using modifiers required to uniquely identify some of the Medicaid services described in Chapter 2 of this handbook.

The modifier field on the CMS-1500 claim form accommodates the entry of up to four two-digit modifiers. Certain podiatry services require a modifier entered after the procedure code to ensure appropriate reimbursement.

Note: Review Chapter 1 of the Provider Reimbursement Handbook, CMS-1500, for additional information regarding the addition of modifiers to a procedure code, on the claim form. All Medicaid handbooks are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Provider Handbooks.

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### **Pricing Modifiers**

A pricing modifier is a two-digit code that is used with a procedure code listed in the fee schedule, to affect the procedure code's fee or cause a claim to be suspended for medical review.

Under certain circumstances the provider is required to use a pricing modifier on the claim form. The circumstances and the associated modifiers required are described throughout Chapter 2 and under the Pricing Modifiers and Their Descriptions section in Chapter 3 of this handbook.

The pricing modifiers are 22, 24, 25, 26, 48, 50, 51, 52, 54, 55, 56, 57, 59, 62, 66, 76, 77, 78, 79, 80, 99, LT/RT, and TC.

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### **Entering Modifiers on the Claim Form**

The modifier is entered in the field next to the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Entering pricing modifiers: Enter the pricing modifier in the first Modifier field on the claim form. Modifier 99 is used when two or more pricing modifiers are applicable to one procedure code line. Do not use modifier 99 when the procedure code has two local-code modifiers. Use of modifier 99 requires claim review by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.

Entering local-code modifiers: Some procedures require two local-code modifiers. Enter the first local-code modifier listed on the crosswalk in the in the first Modifier field on the claim form, and enter the second local-code modifier in the second Modifier field. For example, for RPICC NGO complex surgery > 1500 grams, enter TG in the first Modifier field and 57 in the second Modifier field.

Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field.

Note: See Chapter 1 in the Provider Reimbursement Handbook, CMS-1500, for additional information regarding entering modifiers on the claim form.

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**Pricing Modifiers and Their Descriptions**, continued

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**By Report**

By Report procedures are reviewed and manually priced for reimbursement. Relevant reports must be submitted with a “By Report” claim. Procedure codes with 99 modifiers, procedure codes marked “R” on the podiatry fee schedule, and other procedures specified in this handbook, are approved and priced by report.

Note: See the Podiatry Fee Schedule for all by report procedure codes, indicated with a “R” in the SPEC column. All Medicaid Fee Schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**22  
Unusual Services**

Use this modifier **only when it is medically necessary** for a provided service(s) that exceed the usual service as described in the CPT. Inappropriate and excessive use of modifier 22 can result in claim denial, or a delay in reimbursement.

Modifier 22 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Documentation must be submitted that clearly indicates why modifier 22 is being used.

Additional documentation will need to be submitted along with routine documentation to indicate why additional reimbursement is being requested: examples include explanation of increased complexity of the service or unexpected complications during a service.

Failure to submit the requested documentation can result in denial of the service, request for more information, or no increase in reimbursement.

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**24  
Separate Evaluation  
and Management  
Services**

Use modifier 24 when an evaluation and management service is performed by the same podiatrist or podiatry group during the postoperative period for a reason unrelated to the original procedure.

A report must be submitted with the claim. Using modifier 24 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing.

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**Pricing Modifiers and Their Descriptions**, continued

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**25  
Separate  
Evaluation and  
Management  
Services**

Use modifier 25 for a significant, separately identifiable evaluation and management service by the same podiatrist or podiatry group on the same day of the procedure or other service.

A podiatrist may need to indicate that on the same day a procedure or service identified by a procedure code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.

The evaluation and management service may be prompted by the symptom or condition for which the procedure or the service was provided. As such, different diagnoses are not required for reporting of the evaluation and management services on the same date. This circumstance is reported by adding the modifier 25 to the appropriate level of evaluation and management service.

Modifier 25 must not be used to report an evaluation and management service that resulted in a decision to perform surgery.

A report must be submitted with the claim. Using modifier 25 requires the claim for evaluation and management services be reviewed by a Medicaid medical consultant for medical necessity and appropriate pricing.

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**26  
Professional  
Component**

Certain procedures include both a professional component and a technical component.

The provider must **only** use modifier 26 when the professional component is reported separately.

It must be noted that the professional component is not reimbursed separately when a podiatrist or members of a group practice perform both the professional component and technical component.

Note: Refer to Claiming the Professional Component section of Chapter 2 of this handbook.

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**Pricing Modifiers and Their Descriptions**, continued

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**50  
Bilateral Procedure**

Modifier 50 is used to identify bilateral procedures, performed during the same operative session. The procedure code that describes the surgical procedure must be followed with modifier 50 on the same claim line of the claim form. Do not bill the procedure code on one claim line without modifier 50 and bill the same procedure code on a different claim line with modifier 50.

For claims requiring medical review, a report must be submitted documenting the service.

Procedure codes billed with modifier 50 reimburse at 150 percent of the maximum allowable procedure code fee, or suspends for multiple surgery pricing if applicable.

Do **not** use modifier 50 when the CPT code description identifies the service solely as a bilateral procedure or identifies the service as “unilateral or bilateral” in the code’s description.

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**51  
Multiple  
Procedures**

Modifier 51 is used when more than one surgical procedure is performed in a single operative session. Using modifier 51 requires an operative report and documentation be submitted with the claim.

The claim will be reviewed by a Medicaid medical consultant, for medical necessity and appropriate pricing.

The primary procedure is determined by the diagnosis and purpose of surgery, and must be indicated first on the claim. Do **not** use modifier 51 with the primary procedure. Use modifier 51 with the subsequent, non-primary, procedure codes entered on the claim form.

Multiple surgical procedures performed on one patient on the same day are reimbursed as follows:

- 100 percent of max allowable fee for primary surgical procedure;
- 50 percent of max allowable fee for secondary surgical procedure; and
- 25 percent of max allowable fee for all other surgical procedures.

Payment for claims submitted with only one procedure code and the modifier 51 will be reimbursed at a reduced rate.

Modifier 51 **cannot** be appended to “add-on” codes.

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***Pricing Modifiers and Their Descriptions***, continued

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**52  
Reduced Services**

Modifier 52 is used under certain circumstances when a service or procedure is partially reduced or eliminated at the podiatrist's discretion.

Reimbursement rate is 90 percent of the maximum allowable fee of the procedure code.

Modifier 52 must be used to report reduced services, without disturbing the identification of the basic service.

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**54  
Surgical Care Only**

Modifier 54 is used to identify the surgical component when only one podiatrist performs a surgical procedure.

Reimbursement rate is 50 percent of the maximum allowable fee of the procedure code.

Preoperative or postoperative management is performed by another podiatrist.

For claims requiring medical review, a report must be submitted documenting that the service was for the surgery only.

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**55  
Postoperative  
Management Only**

Modifier 55 is used to identify the postoperative component of patient management.

Modifier 55 is associated with related claims when the surgical procedure and preoperative management have been performed by other podiatrists.

Reimbursement rate is 30 percent of the maximum allowable fee of the procedure code.

For claims requiring medical review, a report must be submitted documenting that the service was for postoperative management only.

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**56  
Preoperative  
Management Only**

Modifier 56 is used to identify the preoperative component including preoperative care and evaluation of patient management.

Modifier 56 is associated with related claims when the surgical procedure and post-operative management have been performed by other podiatrists.

Reimbursement rate is 20 percent of the maximum allowable fee of the procedure code.

For claims requiring medical review, a report must be submitted documenting that the service was for preoperative management only.

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**Pricing Modifiers and Their Descriptions**, continued

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**57  
Decision for  
Surgery**

Modifier 57 is used to indicate an evaluation and management service that results in the initial decision to perform a surgical procedure.

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**59  
Distinct Procedural  
Service**

Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed on the same day.

Procedures that normally would be considered an integral component of another procedure performed or ordinarily not performed at the same operative session should be billed with modifier 59. Documentation must clearly indicate the reason this procedure should be considered for payment separately.

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**76  
Repeat Procedure  
by Same Podiatrist**

Modifier 76 is used when a procedure is repeated by the same podiatrist who performed the original procedure.

Modifier 76 is valid **only** for radiology procedure codes (70000-79999).

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**77  
Repeat Procedure  
by Another  
Podiatrist**

Modifier 77 is used in circumstances when a repeat procedure is performed by another podiatrist on the same date of service.

Modifier 77 is valid **only** for the radiology procedure codes (70000-79999).

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**78  
Operating Room  
Related Procedure**

Modifier 78 is used when another surgical procedure is performed during the postoperative period.

The initial surgery must have been performed by the same podiatrist or podiatry group.

An operative report must be submitted with the claim.

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**79  
Operating Room  
Unrelated  
Procedure**

Modifier 79 is used to identify a return trip to the operating room unrelated to a previous surgery.

The return trip to the operating room is during the postoperative period when the service is provided by the same podiatrist or podiatry group that performed the surgical procedure relating to the postoperative period.

An operative report must be submitted with the claim.

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**Pricing Modifiers and Their Descriptions**, continued

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**80  
Assistant Surgeon**

Modifier 80 is used to identify procedures that require medically necessary surgical assistant services.

Only one assistant surgeon may be reimbursed for each operative session.

Modifier 80 reimburses at 16 percent of the maximum fee for the procedure code.

Multiple surgical procedures are reimbursed as follows:

- 16 percent of 100 percent of the maximum allowable fee for the primary surgical procedure (first claim line);
- 16 percent of 50 percent of the maximum allowable fee for the second surgical procedure; and
- 16 percent of 25 percent of the maximum allowable fee for all other surgical procedures.

For assistant surgeon claims always place the 80 modifier in the first modifier field, regardless of other pricing modifiers.

Note: See the Physician Surgery Fee Schedule for procedure codes that allow assistant surgeons to bill, as indicated with an “AS” in the SPEC column of the Podiatry Fee Schedule. All Medicaid fee schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

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**99  
Multiple Modifiers**

Modifier 99 is used when two or more modifiers are applicable to one procedure code line.

When modifier 99 is used, there must be an indication made on the first page of the submitted documentation indicating the specific individual modifiers that 99 represents (Example: 99=80, 51). Absence of this indication can result in a claim line denial.

Using modifier 99 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.

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**Pricing Modifiers and Their Descriptions**, continued

**LT/RT  
Left and Right  
Radiology  
Modifiers**

Use modifiers to indicate left (LT) or right (RT), for radiology procedures only.

These modifiers are valid for only radiology procedure code ranges 70000-79999.

Radiology procedure codes allowed to be used with the left and right modifiers are indicated with a "LT/RT" in the modifier column of the Physicians Radiology Fee Schedule.

Note: See the Physician Radiology Fee Schedule for radiology codes that allow left/right modifiers. All Medicaid fee schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.

**TC  
Technical  
Component  
Radiology**

Certain procedures include both a professional component and a technical component.

Procedure codes reimbursable with a technical component are radiology procedure codes (70000-79999), for services rendered in the physician office setting only.

Use the TC modifier when the radiological technical component is reported separately.

Procedure codes that are allowed to be used to bill a technical component are indicated in the "TC" column of the Physician Radiology Fee Schedule.

Note: See the Physician Radiology Fee Schedule for procedure codes that allow a TC modifier. All Medicaid fee schedules are available on the Medicaid Web Portal at <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Fee Schedules.









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