# Handbook for Providers of Podiatric Services

# Chapter F-200 Policy and Procedures for Podiatric Services

**Illinois Department of Healthcare and Family Services**

**Issued October 2016**

# Chapter F-200

# Podiatric Services

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# Foreword

## Purpose

This handbook, along with recent provider notices, will act as an effective guide to participation in the Department's Medical Programs. It contains information that applies to fee-for-service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation as well as information on which services require prior approval and how to obtain prior approval.

It is important that both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updated handbooks are posted on the Provider Handbooks page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification, when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

# Acronyms and Definitions

**Department of Healthcare and Family Services (HFS) or (Department)** - The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs.

**Document Control Number (DCN)** – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS or YDDDLLSSSSSS.

CCY Century and decade in which claim was received
Y Last digit of year claim was received
DDD Julian date claim was received
LL Document Control Line Number
SSSSSS Sequential Number

**Fee-for-Service** – A payment methodology in which reimbursement is considered for each service provided.

**HCPCS** – Healthcare Common Procedure Coding System.

**HFS 1443** – The Department of Healthcare and Family Services Provider Invoice claim form.

**HFS 2432** – The Split Billing Transmittal for MANG Spenddown Program Form issued by the Department of Human Services.

**HFS 3797** – The Department of Healthcare and Family Services Medicare Crossover Invoice claim form.

**Identification Card or Notice** - The card issued by the Department to each person or family who is eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

**National Drug Code (NDC)** - A universal product identifier for human drugs that is required by the Food and Drug Administration (FDA) pursuant to requirements under the Drug Listing Act of 1972. The National Drug Code (NDC) is a three-segment number. The first segment identifies the product labeler. The second segment identifies the drug, strength, and dosage form. The third segment identifies the package size and type.

**National Provider Identifier (NPI)** - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

**Participant** – A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient".

**Procedure Code** – The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

**Provider Enrollment Services (PES)** – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

**Recipient Identification Number (RIN)** – The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

**Remittance Advice** – A document issued by the Department which reports the status of claims (invoices) and adjustments processed. This document may also be referred to as a voucher.

**Telemedicine** – The use of a Telecommunication System to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another medical provider location.

## F-200 Basic Provisions

For consideration of payment by the Department for podiatry services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Services provided must be in full compliance with applicable federal and state laws, the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook apply to participants enrolled in traditional fee-for-service and **do not apply** to patients enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Providers submitting X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 Handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

# F-201 Provider Participation

## F-201.1 Podiatrist Enrollment

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented a new electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

Refer to IMPACT Provider Types, Specialties and Subspecialties for additional information.

## F-201.2 Participation Approval

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix F-4.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic F-201.4.

## F-201.3 Participation Denial

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C.

## F-201.4 Provider File Maintenance

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

### Provider Responsibility

Information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments.

### Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider's office address and to all payees listed if the payee address is different from the provider address.

# F-202 Podiatrist Reimbursement

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided or materials dispensed. Any payment received from a third-party payor or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department for those services or items.

## F-202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

To be paid for services, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service. The Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than twenty-four (24) months from the date of service.

It is the provider's responsibility to verify claims are received by the Department, whether submitted electronically or on paper, and to check claim status.

A podiatrist may charge only for services personally provided, or which are provided under his/her direct supervision in the podiatrist's office by ancillary licensed or certified staff, e.g. laboratory tests performed by a technician in the podiatrist's employ. A podiatrist may not charge for services provided outside the podiatrist's office by anyone other than that podiatrist.

A podiatrist may not charge for services provided by another podiatrist even though one may be in the employ of the other. The treating podiatrist, if it is a condition of employment, may elect to have payment directed to the employing podiatrist under the alternate payee option allowed in the provider enrollment process.

A podiatrist providing any services in a hospital setting may charge for the services only if he/she is not reimbursed by the hospital and the hospital does not include the cost of the podiatrist's services in the hospital's reimbursable cost report. It is the responsibility of the podiatrist, if charges are made for such services, to verify that the services provided are not included as part of the contract with the hospital.

Covered services must be billed to the Department using the Current Procedural Technology (CPT) codes or alphanumeric HCPCS codes.

Charges for services and items provided to participants enrolled in a Managed Care Managed Care Organization (MCO) or Managed Care Community Network (MCCN) must be billed to that entity according to the contractual agreement with the MCO or MCCN. Information regarding MCOs and MCCNs can be found on the HFS Care Coordination web page.

### Allowable Charges by Teaching Podiatrists

Teaching podiatrists who provide direct patient care may submit charges for the services provided, if the salary paid to them by the hospital or other institution does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

Charges are to be submitted only when the teaching podiatrist seeking reimbursement has been personally involved in the services being provided. In the case of surgery, this means presence in the operating room, performing or supervising the major phases of the services, taking personal responsibility for the services provided, and personally performing services considered necessary to confirm the diagnosis and findings. For non-surgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching podiatrist is personally responsible for all services provided and is personally involved by having direct contact with the patient.

The patient's medical record must show that these requirements have been met. All such entries must be signed and dated by the podiatrist seeking reimbursement. A signature may be handwritten or electronic; signature stamps are not acceptable.

## F-202.2 Electronic Claims Submittal

Refer to Chapter 100 for general policy and procedures regarding claim submittal.

Services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 300, 5010 Companion Guide.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the billing method being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

## F-202.3 Claim Preparation and Submittal

The Department will not accept paper claim forms hand-delivered to HFS office buildings by providers or their billing entities. HFS will return hand-delivered claims to the provider identified on the claim form. All services for which charges are made must be coded on the appropriate claim form.

For general information on billing Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to the Chapter 100 Handbook.

Form HFS 1443, Provider Invoice, is to be used to submit charges for all podiatry services provided other than Medicare covered services. Detailed instructions for completion are included in Appendix F-1.

Form HFS 3797, Medicare Crossover Invoice, is to be used to submit charges for all Medicare covered podiatry services. Detailed instructions for completion are included in Appendix F-2.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendices F-1 and F-2 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately seven to ten working days and providers are notified of the evaluation results in writing.

Please send sample claims with a request for evaluation to the following address:

Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

## F-202.4 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department.

Refer to Chapter 100 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

For participants eligible for Medicare Part B benefits, payment will be considered on the Medicare cost-sharing amounts and/or for the Department’s Medical

Programs covered services that are not covered by Medicare. If the Department's rate is lower than Medicare's rate, it may result in no payment being due. Refer to Chapter 100.

## F-202.5 Fee Schedule

Fee schedules, including the Podiatry Fee Schedule, are posted to the Department's website under the Provider Medicaid Reimbursement page. The listings identify the allowable procedure codes by provider type.

The Department will notify providers regarding major policy and procedural changes via a provider notice posted to the website. Provider notices will not be released for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

Providers should sign up to receive electronic notification of new releases, including fee schedule updates, on the Department's website. Please mark "All Medical Assistance Providers" as well as each specific provider type for which notification is requested.

## F-203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Adm. Code 140.3. Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The services covered in the podiatry program are limited and include only essential services for the diagnosis and treatment of conditions of the feet and ankles. The Department determines the medical necessity of the service on the basis of the information submitted by the podiatrist.

While the various procedure codes listed in the fee schedules are to be used to designate services provided or procedures performed, such listing does not necessarily assure payment. Any questions a provider may have about coverage of a particular service should be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 1-877-782-5565.

If services are to be provided to a participant enrolled in Coordinated Care, prior authorization and payment must be obtained from that entity.

## F-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

Additionally, the following podiatry services are excluded from coverage and payment cannot be made for these services:

- Making a referral, obtaining a specimen, handling a specimen for analysis, or ordering a laboratory test.
- Visits and services provided to participants eligible for Medicare benefits if the services are determined not medically necessary by Medicare.
- Services provided to participants in long term care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of such facility.
- Routine foot care, except as described in Topic 210.2.
- Screening for foot problems (services performed in the absence of localized illness, symptoms or injury involving the foot or toe).
- Provider transportation costs.
- X-ray and laboratory procedures performed at a location other than the podiatrist's own office.
- X-rays, laboratory work, or similar services not specifically required by the primary condition for which the participant is being treated.
- Co-surgeons.
- Services that are available free of charge from other sources including, but not limited to, private and governmental agencies.
- Any services billed in association with non-covered services, such as X-ray, laboratory, routine visits, etc.

# F-205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action. See Chapter 100 for record requirements applicable to all providers. The retention requirements are not intended to replace professional judgment, nor do they supersede record retention requirements under law or regulations of other agencies. The podiatrist may choose to retain records beyond the Department's required period.

## F-205.1 Office Record

Podiatrists must maintain an office medical record for each participant. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific provider rendering the services.

The record is to include the essential details of the participant's health condition and of each service provided. Any services provided to a participant by the podiatrist outside the podiatrist's office are to be documented in the medical record maintained in the podiatrist's office. All entries must include the date, time, and signature of the podiatrist rendering the service, and must also be legible and in English. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted. Transcription may be required for purposes of peer, quality of care, or utilization reviews by the Department.

### F-205.1.1 Consultations

The record requirement for a consultation is a copy of the report that was made available to the provider requesting the consultation.

### F-205.1.2 X-rays

Department requirements for retention of records as stated in Chapter 100 are applicable to X-rays and records of film-like nature. X-rays maintained as a part of the medical record must show the participant's name and the date the X-rays were performed. The right or left foot must be designated. The Department has no objections to microfilming X-rays when it is done in compliance with applicable State laws.

## F-205.2 Services Provided in an Institution

Although the primary medical record indicating the participant's condition, treatment and services ordered and provided during a period of institutionalization may be

maintained as a part of the facility chart, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the podiatrist as an office record to show continuity of care.

# F-210 General Limitations and Considerations on Covered Services

Certain services are covered only when provided in accordance with the limitations and requirements described below.

## F-210.1 Services to Participants Ages 0 through 20 Years

Federal regulations require that persons less than 21 years of age who have congenital or acquired crippling conditions or conditions leading to crippling, **must be referred to the Division of Specialized Care for Children (DSCC) for evaluation**. A crippling condition in this context is a tissue or functional defect of bone, muscle and joint origin that is chronic, or if unattended, may lead to chronicity with subsequent disability and handicap. Persons in this age group with congenital or acquired systemic disease which may also involve the feet, or foot conditions which are associated with, or may lead to impairment of the musculoskeletal system beyond the feet (knees, hips) and those who require specialized health providers for proper evaluation, treatment design and management are to be referred to DSCC.

Examples of conditions that require referral to DSCC include the following severe or complex orthopedic handicaps involving the foot:

- Congenital club feet
- Congenital metatarsum varus; adductus metatarsus primus varus; Hallux varus requiring surgical treatment
- Tarsal coalition (rigid flat or peroneal spastic flatfoot)
- Congenital cleft foot (lobster claw)
- Pes cavus, pes cavorvarus
- Toe walker (e.g., congenital short heel cord) congenital contractures of triceps (sural muscle)
- Symptomatic pes planovalgus
- Malignant tumors
- Other conditions, unusual or severe, that may be crippling or lead to crippling

## F-210.2 Routine Foot Care Services

Routine services (trimming of nails, treatment of calluses, corns, and similar services) are not covered except when a participant is under active treatment for diabetes mellitus or has a systemic condition that has resulted in severe circulatory impairment or an area of desensitization in the legs or feet and routine type foot care is required. In such instances care may not be provided in less than 60-day intervals. For residents in long term care facilities the routine services are covered only when the participant's medical record corroborates one or both of these conditions.

The podiatrist's records are to contain medical information pertinent to the diagnosis or condition that qualifies the patient for routine care, including the attending physician's name and description of treatment being provided by that physician for the diagnosis.

## F-210.3 Orthomechanical Services

The provision of orthotics (orthomechanics) requires prior approval. See Section F-211 Prior Approval Process. Approval will be considered for orthotics only when it has been established that there is no practical and more economical alternative method of treatment for the participant's condition.

Refer to the Podiatry Procedure Code Fee Schedule for the covered HCPCS requiring a Prior Approval. These are the only services billable by the podiatrist. For services not listed in the Podiatry Procedure Code Fee Schedule, the patient should be referred to an enrolled Illinois Medicaid provider of Medical Equipment and Supplies. Refer to the Handbook for Providers of Medical Equipment and Supplies for an explanation of policy and procedures relating to orthotics.

# F-211 Prior Approval

Prior to the provision of certain services, and/or dispensing of certain materials, approval must be obtained from the Department. See the Podiatry Procedure Code Fee Schedule listing for services requiring prior approval. **If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed.** See Chapter 100 for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

**Orthomechanics:** Approval for bilateral items is made for a quantity of “1” for each side; the first side under the specific CPT or HCPCS code, and the other side under the unlisted code 99199.

If a participant becomes enrolled in an MCO or MCCN during a period of time for which a prior approval has been previously granted, the prior approval will no longer be applicable, effective with the participant’s managed care enrollment date. Prior approval requests for participants in an MCO or MCCN should be directed to the individual plan.

## F-211.1 Prior Approval Requests

Prior approval requests must contain enough information for Department staff to make a decision on medical necessity, appropriateness and anticipated patient benefits of the service.

The single most common reason for a delay in processing prior approval requests is lack of adequate information upon which to make an informed decision.

The exact information needed will vary depending on the service requested and the medical condition of the patient, but the process described below is designed to cover the general information that is needed for all requests.

Prior approval requests may be submitted to the Department by mail or fax.

**By Mail:**

The provider is to complete form HFS 1409 , Prior Approval Request, when requesting covered services. Instructions for its completion are found in Appendix F-3. All forms must be signed in ink by the provider or his or her designee.

The form must be accompanied by the following documentation.

- Podiatry order
- Progress notes
- For hand-priced codes for products (see Podiatry Fee Schedule ) include the product description and manufacturer invoice
- For diabetic shoes and inserts (see Podiatry Fee Schedule) include a copy of the attending provider certified statement verifying patient is under current treatment for condition

**By Fax:**

Prior approval may be requested by fax. Complete Form HFS 1409 following the procedures described above for mailed requests. The completed form and other associated documents can be faxed to 217-524-0099. Providers should review the documents before faxing to ensure that they will be legible upon receipt. Colored documents do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

The fax number for **initial and renewal prior approval requests** is 217-524-0099.

The fax number for **additional information and change requests** of an existing prior approval is 217-558-4359.

The fax lines are available Monday through Friday, 8:30 AM to 5:00 PM, except holidays.

## F-211.2 Approval of Service

If the service requested is approved, the provider and the patient will be mailed a computer-generated letter, Form HFS 3076A, Prior Approval Notification, listing the approved services. Upon receipt of the Prior Approval Notification, the item may be dispensed and billed.

Any changes/corrections needed to the prior approval notification HFS 3076A, must be submitted as a review via mail or fax with supporting documentation to the prior approval unit. The prior approval fax line to receive reviews is 217-558-4359.

## F-211.3 Denial of Service

If the service requested is denied, a computer-generated Form HFS 3076C, citing the denial reason, will be sent to the patient and the provider. **The provider cannot file an appeal of the denial; only the patient may file an appeal**. If the provider obtains additional information that could result in a reversal of the denial, the provider may submit a new prior approval request with the supporting medical information attached.

## F-211.4 Timelines

The Department is obligated to make a decision on podiatric prior approval requests within 30 days of the Department's receipt date, as specified in accordance with 89 Illinois Administrative Code 140.Table E, Time Frames for Processing Prior Approval Request. Decisions must be made within the time frame established with exceptions as described below. If the Department fails to make a decision within the specified time frame, the item or service is automatically approved, but for a minimum time period. If an item or service has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the provider who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the thirty (30) day period stops. When the required information is received, a new thirty (30) day period begins. An HFS 3701 will be generated when additional information is required.

The provider can request status of a prior approval after thirty (30) days from the Department's receipt date. This can be done by calling the prior approval unit at 1-877-782-5565.

## F-211.5 Post Approval

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the participant's eligibility for the Department's Medical Programs was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than ninety (90) days following the Department's Notice of Decision approving the patient's application.

- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third party payer within six months following the date of service, as well as a copy of the denial from that third party, must be supplied with the request for approval. The request for post approval must be received no later than ninety (90) days from the date of final adjudication by the third party.

- The patient did not inform the provider of his or her eligibility for medical assistance. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the participant each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval must be met, and post approval requests must be received by the Department no later than ninety (90) days from the date services or items are provided or within the time frames identified above.

Providers have 180 days from the date of the post approval to bill the Department. If necessary, the Department will override the timely filing limit.

# F-220 Evaluation/Management Services

## F-220.1 Illinois Health Connect

Services rendered by providers who are not enrolled as PCPs, including podiatrists, do not need a referral from a participant's PCP at this time. Providers will be informed via an informational notice when these services will require a referral.

For more information on referrals contact IHC at 1-877-912-1999.

## F-220.2 Office or Other Outpatient Visits

Charges may be submitted for evaluation and management services provided by a podiatrist in the office setting that are essential for the diagnosis and/or treatment of specific illness, surgical condition, or injury. The selection of an evaluation and management CPT code is to be based on the primary reason for the visit, the level and place of service, and whether the visit is for a new or an established patient.

### F-220.2.1 Therapeutic Procedure Performed During the Office Visit

When a therapeutic procedure is performed during an office visit, reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, but not for both unless it is an initial visit.

### F-220.2.2 New Patient vs. Established Patient Classification

A participant may be designated as a "new patient" only once in a lifetime by an individual podiatrist, partner of the podiatrist, or collectively in a group, regardless of the number of providers who may eventually see the participant. When a participant is transferred within a group practice setting, a new patient procedure code is not to be used. The visit is classified as for an established patient.

## F-220.3 Outpatient Services

### F-220.3.1 Referred Services

A podiatrist may refer patients for essential covered services such as laboratory tests, X-ray examinations, etc., which are provided by a hospital on an outpatient basis. No charge may be made by the podiatrist for such a referral or for services not personally provided by the podiatrist.

### F-220.3.2 Non-Emergency Services

When a podiatrist sees a participant in the outpatient department of a hospital on a non-emergency basis, for the convenience of either the participant or the podiatrist, the visit is considered the same as an office visit.

**Procedure:** If a charge is being submitted for the visit, the appropriate Evaluation and Management CPT code is to be entered on the billing form. The Place of Service must be "11", Office. Charges are to be made for procedures as indicated for Evaluation and Management Services, Topic F-220.2.

## F-220.4 Hospital Inpatient Services

The podiatrist may charge for subsequent visits to hospitalized patients no more frequently than once daily. All visits and services for which charges are made must be documented in the patient's hospital record.

## F-220.5 Consultations

A consultation is the service rendered by a podiatrist, at the request of another practitioner, with respect to the diagnosis and /or treatment of a particular illness or condition involving the participant. The consultation service is considered the entire package of podiatrist services required to arrive at a decision and/or recommendation regarding a participant's condition and plan of treatment.

The consultation claim must be submitted with the name and NPI of the referring practitioner in the appropriate fields. A written report from the consulting podiatrist to the requesting practitioner is to be included in both the consulting and referring providers' medical records.

## F-220.6 Telehealth

Telehealth is the use of a telecommunication system to provide medical services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation and treatment. Medical data exchanged can take the form of multiple formats: text, graphics, still images, audio and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications. The telecommunication system must, at a minimum, have the capability of allowing the consulting provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs.

Telephones, facsimile machines, and electronic mail systems are not acceptable telecommunication systems.

Under the Department's telehealth policy, providers will be paid as either an Originating Site or Distant Site. Refer to Appendix F-6 for billing examples.

### F-220.6.1 Originating Site (Patient Site)

The Originating Site is the location where the participant receiving the telehealth service is located. Originating Site providers may receive reimbursement for a facility fee for each telehealth service. Providers eligible to receive a facility fee are physician's office, podiatrist's office, local health departments, community mental health centers and outpatient hospitals. In order to receive reimbursement for the facility fee, Originating Site providers must bill the appropriate procedure code for a Telehealth originating site facility fee.

For telemedicine services, a physician or other licensed health care professional must be present at all times with the patient at the Originating Site.

### F-220.6.2 Distant Site (Provider Site)

The Distant Site is the site where the provider rendering the telehealth service is located. Providers rendering telemedicine services at the Distant Site shall be reimbursed the Department's rate for the CPT Code for the service rendered. The appropriate CPT Code must be billed with modifier GT (via interactive audio/video telecommunication systems).

Enrolled Distant Site providers may not seek reimbursement from the Department for their services when the Originating Site is an encounter clinic. The Originating Site encounter clinic is responsible for reimbursement to the Distant Site provider.

Non-enrolled providers rendering services as a Distant Site provider shall not be eligible for reimbursement from the Department, but may be reimbursed by the Originating Site provider from their facility fee payment.

For telemedicine services, the provider rendering the service at the Distant Site can be a physician, physician assistant, podiatrist or APN who is licensed by the State of Illinois or by the state where the participant is located. Services rendered by an APN can be billed under the collaborating physician's NPI, or if the APN is enrolled, under the APN's NPI. When medically appropriate, more than one Distant Site provider may bill for services rendered during the telehealth visit.

## F-220.7 Long Term Care Facility Visits and Procedures

Charges may be made for a long term care facility visit and for any procedures performed by the podiatrist at the time of the visit in accordance with policy applicable to office services (see Topic F-220.2).

A podiatrist may submit charges for essential services to a participant in the participant's place of residence (i.e., home, long-term care facility, or sheltered care and other custodial facility) when the participant is physically unable to go to the podiatrist's office. The appropriate CPT Code and place of service are to be used for the specific service provided. All services provided by a podiatrist to a participant in a long-term care facility are to be documented in the participant's record maintained in the facility.

### A-220.7.1 Referrals

A practitioner may refer a participant in a long-term care facility for covered services to a podiatrist when there is an identifiable medical need of the participant for the specific type of service. The podiatrist to whom referral is made is responsible for obtaining any necessary authorization from the Department prior to rendering the service.

### A-220.7.2 Non-covered Services

Services for which payment will not be made when rendered in the long-term care setting include, but are not limited to, the following:

- Routine, non-individually essential visits
- Screening services
- Visits to a participant eligible for Medicare benefits when determined by Medicare to not be medically necessary
- Non-emergency services to a participant by a podiatrist without referral from the attending practitioner and participant's knowledge and permission

In addition to the above, no charges may be made for services provided to participants in a long-term care facility by a provider who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility except:

- Emergency services provided for acute illness
- When there is no other available facility in the area for essential treatment for short-term care pending transfer
- When there is no comparable facility in the area

# F-222 Surgery

## F-222.1 Surgical Services – Office

When charges are made for essential surgical procedures done in the podiatrist's office, no additional charge may be made for the office visit. Customary surgical dressings, trays, or other materials used in conjunction with a surgical procedure are considered a part of the surgical procedure.

A charge is not to be submitted for post-operative office visits and treatment following surgery for a minimum of thirty days.

### F-222.1.1 Anesthesia

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

### F-222.1.2 Dressings

For customary surgical dressings no charges may be made in addition to the office visit or procedure charge. For dressings, which are unusually extensive or required in large amounts, (e.g., medicated dressings) charges may be made if substantiating clinical data is submitted with the paper HFS 1443.

**Procedure:** The unlisted office supply CPT Code must be billed and the specific item identified in the description field of the paper HFS 1443. A copy of the invoice showing the actual cost must be submitted with the HFS 1443.

### F-222.13 Wound Treatment

Charges may be made for surgical debridement when substantiating information is submitted. No additional charge may be made for the evaluation and management CPT Code.

**Procedure:** The appropriate CPT Code is to be used to submit charges for surgical debridement. Charges must be submitted on the paper HFS 1443 with a copy of the notes attached.

## F-222.2 Surgical Services – Hospital

### F-222.2.1 Covered Procedures

Surgical procedures are allowable when they are medically necessary, recognized as standard medical care, and required for the immediate health and well-being because of illness, disability, infirmity, or impairment.

The Department may request operative reports as necessary in order to determine payment. The report provided to the Department must be a photocopy of the official operative report on file at the facility. The date of surgery on the operative report must match the service data shown on the claim, and the name of the operating surgeon shown on the operative report must exactly match the name of the billing surgeon.

### F-222.2.2 Global Postoperative Period

Charges submitted for a major operative procedure (as displayed on the Podiatry Fee Schedule under Surgery Indicator) include the pre-surgical examination subsequent to the decision for surgery and rendered on the date of surgery or the day immediately prior. These charges also encompass complete postoperative care including postoperative office visits and customary wound dressings for a period of 30 days.

Charges submitted for a wound procedure (such as debridement, with placement of skin substitute) include postoperative visits, wound care, and dressing changes for a period of seven (7) days after the surgical procedure.

### F-222.2.3 Multiple/Complex Procedures

When submitting charges for multiple procedures and/or complex surgeries, the podiatrist is to attach the operative report to the paper HFS 1443.

Additional procedures may be paid at a lesser rate or may be rejected as part of the surgical package. Surgical procedures considered incidental to, or a component of, the major procedure will not be paid separately from the major code.

### F-222.2.4 Multiple Operative Sessions on the Same Day

When a participant has more than one separate operative session on the same day, the operative reports for all sessions showing the separate operative times must be attached to all subsequent paper HFS 1443 claims.

## F-222.3 Podiatrists Rendering Surgical Assistance

Surgical assistance is a covered service only when provided for major or complex surgical procedures. Procedure Codes payable for surgical assistance are identified on the Podiatry Fee Schedule.

If the presence of a surgical assistant is required by hospital bylaws on other than a major surgical procedure, reimbursement for such service will be considered only if a photocopy of the hospital's bylaws accompanies the bill.

Payment is made for only one surgical assistant. The podiatrist who serves as the assistant surgeon is to submit charges to the Department.

**Procedure:** Enter the appropriate Procedure Code for the major surgical procedure on the paper HFS 1443. Enter the code "F" in Field 4 (Role) to denote that the charge is as an Assistant Surgeon. Enter modifier "AS" in the Modifier Field. Complete the "Units/Quantity" Field of the service section showing the time required to assist at the surgery. Enter the actual time in minute format, e.g., the entry for 1 hour and 10 minutes is "0070".

When the surgical assistance time billed is eight hours or more (480 minutes or more), documentation, e.g., a copy of the operating room record, which shows the time surgery began and ended, must be attached to the paper HFS 1443 for reimbursement consideration. The report must specify the amount of time required for the surgery. A narrative signed by the assisting podiatrist verifying the amount of time is also acceptable.

### F-222.4 Surgical Wound Treatment and Skin Substitutes

Podiatrists may submit charges for surgical wound treatment, including debridement and application of skin replacements or substitutes (grafting). An evaluation and management visit on the same day as the surgical burn treatment by the same podiatrist is not reimbursable.

Claims must be submitted on paper, using the CPT Code appropriate for the location and type of wound preparation and application of grafts. Operative reports must be attached to the claim form. The CPT Code for the initial procedure is billed with Units/Quantity Field showing quantity "1". The subsequent service section should contain the CPT Add-On Code for all additional square cm or percent body area, with the total additional quantity shown in the Procedure Description Field, and with the Units/Quantity Field showing quantity "1".

**Procedure for Skin Substitutes** – Claims must be submitted on paper claim Form HFS 1443, using the appropriate CPT or HCPCS Code. Operative reports and a copy of the product invoice must be attached to the claim form. The procedure code is billed with the Units/Quantity Field showing quantity of "1" and the number of square centimeters reported in the procedure description box of field 23.

# F-224 Radiology Services

Radiology and X-ray services are covered when essential for the diagnosis and treatment of disease or injury to the foot and/or ankle.

## F-224.1 Podiatrist Radiology Billing

A podiatrist may charge for X-ray examination performed in his office, by his own staff, using his equipment and supplies. Allowable procedures are listed in the fee schedule.

- A central X-ray department serving podiatrists in a group practice is considered a part of the podiatrist's office.
- Routine screening X-rays are not covered.
- When X-rays are the only service provided at the time of a visit, an office visit charge may not be made.
- Charges may not be submitted for X-rays that are not readable.

## F-224.2 Ordered or Referred Radiology Services

For necessary radiology services not provided in the podiatrist's office, the podiatrist is to refer to 1) the outpatient department of a participating hospital, 2) a radiologist in private practice, 3) an imaging center, or 4) a Medicare-certified independent diagnostic testing facility. The podiatrist is to include his state podiatric license number and the participant's diagnosis, presenting symptoms, or the conditions that indicate the medical need for the specific tests ordered. The podiatrist may not charge for such a referral.

# F-225 Diagnostic Laboratory Services

Only those laboratory tests and examinations that are essential for diagnosis and evaluation of treatment are covered. Payment is not allowed for laboratory tests for the purpose of screening.

## F-225.1 Podiatrist Laboratory Billing

A podiatrist may charge only for those tests performed in the podiatrist's office by the podiatrist's staff, using his equipment and supplies. Allowable procedures are listed in the fee schedule.

- Payment made by the Department for laboratory tests performed in the podiatrist's office includes both the professional and technical component fees.
- A podiatrist may not charge for laboratory tests when a specimen is obtained but sent out of the office, e.g. blood work, skin lesions, etc.
- A central laboratory serving podiatrists in a group practice is considered to be a podiatrist's office laboratory, except where the laboratory is a Medicare-certified clinical laboratory.
- When the participant presents for laboratory tests only, an office visit charge may not be made.

Podiatrists providing laboratory services in an office setting must be in compliance with the Clinical Laboratory Improvements Amendment (CLIA) Act and must have a current CLIA certificate on file with the Department. For more information regarding laboratory registration, permits, and/or full licensure, contact the Illinois Department of Public Health, Division of Health Care Facilities and Programs.

## F-225.2 Ordered or Referred Laboratory Services

For necessary laboratory tests not provided in the podiatrist's office, the podiatrist is to refer to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory. The podiatrist is to include his NPI and the participant's diagnosis, presenting symptoms, or the conditions that indicate the medical need for the specific tests ordered. The podiatrist may not charge for such a referral.

## F-250 Podiatrist-Administered Drugs

Reimbursement for certain podiatrist-administered drugs may be made to podiatrists. The drug must have been purchased by the podiatrist and must be administered in the office setting in order to be submitted on the professional claim. Medications charged through a pharmacy or facility are not billable.

Submit the appropriate CPT or HCPCS Code(s) to identify the drug. When a specific code is not available, an unlisted medication CPT or HCPCS code may be used. The corresponding description field must contain the name of the drug, strength of the drug, and amount given. NDC billing instructions located in Appendix F-5 must be followed.

**Please Note**: When billing medication administered from a multi-use vial, the amount billed must only be the quantity of the drug actually administered. Claims submitted for an entire vial when, in fact, only a partial vial was used are subject to audit and/or recoupment of any payment made for the unused portion of the medication.

While coverage for injectable drugs is considered separately from visits or injection administration, the injection procedures themselves (such as tendon injections) are considered therapeutic procedures. Reimbursement will be made for whichever service the Department prices higher, either the visit or the procedure, as previously described in F-220.2.1, Therapeutic Procedure Performed During the Office Visit.

# F-280 Pharmacy/Medical Equipment/Medical Supplies

When the podiatrist determines that an individual has a medical need for a pharmacy item, medical equipment or supplies, a prescription or an order may be written. The individual may obtain the item from a durable medical equipment or pharmacy provider enrolled with the Department. If the item requires prior approval, the dispensing provider will be required to obtain prior approval from the Department before reimbursement can be authorized. Refer to Chapter P-200, Handbook for Providers of Pharmacy Services and Chapter M-200, Handbook for Providers of Medical Equipment and Supplies for prior approval requirements.

## F-280.1 Medical Equipment and Supplies Dispensed in a Podiatrist's Office

Coverage is limited to those items that are required following a treatment plan for a specific medical condition. The Department does not reimburse for medical supplies (e.g. rubber gloves) dispensed by a podiatrist that are not durable or reusable. Medical supplies are not to be dispensed or prescribed for a participant's personal convenience.

**Procedure:** The unlisted office supply CPT Code must be billed, and the specific item must be identified in Field 23, Procedure Description, of HFS 1443. A copy of the invoice showing the actual cost must be submitted with the HFS 1443.

## F-280.2 Home Medicine Chest Items

Home medicine chest items may be prescribed only when a participant's need for a specific item is extended or the item is necessary in large quantities for a specific therapeutic reason. Such items include, but are not limited to: petroleum jelly, gauze, adhesive tape, rubbing alcohol, etc.

## F-280.3 Prescription Requirements

The Department reimburses for prescription and over-the-counter pharmacy items that are essential for the accepted medical treatment of a participant's symptoms and diagnosis. In order to obtain the pharmacy item, the participant must have a prescription, and the item must be dispensed in accordance with the following requirements and limitations. A prescription is required for both prescription and over-the-counter pharmacy items.

Drug coverage is limited to those products made by drug manufacturers who have signed drug rebate agreements with the federal government. A listing of rebating manufacturers is distributed quarterly by the Department.

The prescriber must use his or her own prescription form and is responsible for entering at least the following minimal information on the form:

- Participant's name
- Date prescription was written
- Name of pharmacy item being prescribed
- Dosage form and strength or potency of drug (or size of non-drug item)
- Quantity
- Directions for use
- Refill directions
- Prescriber's NPI
- Legible signature in ink

Federal law requires that all non-electronic Medicaid prescriptions be written on tamper-resistant prescription pads. The federal requirement does not apply to electronic prescriptions. An electronic prescription is one that is transmitted from the prescriber to the pharmacy via telephone, telefacsimile, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission. The Department strongly encourages providers to use an electronic method to transmit prescriptions to pharmacies.

To be considered tamper-resistant, a prescription pad must contain at least one of each of the following characteristics:

1) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank form;
2) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

This requirement applies to all prescriptions regardless of whether HFS is the primary or secondary payer.

Podiatrists are to prescribe, and pharmacies are to dispense, medication in quantities reasonably calculated to meet the predictable needs of the participant as long as this does not exceed the designated maximum quantity.

The completed prescription form is to be given to the participant to take to the pharmacy of the participant's choice; however, a podiatrist may telephone or electronically transmit a pharmacy to prescribe, provided that the participant is permitted free choice of pharmacy.

The participant's medical record in the podiatrist's office is to contain entries regarding all drugs, medications with dosages, and medical supplies which are prescribed or dispensed, and the participant's response to the treatment.

## F-280.4 Non-Covered Pharmacy Items

Prescription pharmacy items that are not covered under the Medical Assistance Program are:

- Drugs manufactured by companies that have not signed a rebate agreement with the federal government.
- Drugs identified by the FDA as being in Drug Efficacy Study Implementation (DESI) status.
- Drugs dispensed after the termination date included on the quarterly drug tape provided by the federal Centers for Medicare and Medicaid Services.

## F-280.5 Group Care Restricted Items

Certain items provided to residents of skilled and intermediate care long term care (LTC) facilities are the responsibility of the facility.

Long Term Care (LTC) facilities are required to provide durable medical equipment and supply items, including wound care dressings, to participants as a part of the per diem reimbursement paid to the facilities by the Department. In addition, certain drug items are considered the responsibility of the LTC facility as a part of their per diem reimbursement. Those drug items are:

- Acetaminophen
- Aspirin
- Zinc Oxide Ointment
- Over-the-Counter drugs, prescribed by the participant's health care provider, which are not covered under the Department's Medical Assistance Program.

Podiatrists cannot bill the Department for these items when provided to participants living in these facilities. The podiatrist is responsible for ensuring that he/she does not bill the Department for these items when dispensed to residents of these facilities.

Drugs considered palliative in nature, or related to the illness for which a patient is receiving hospice care, are the responsibility of the hospice. These drugs should be provided by the hospice.