Podiatry
# PART II
## PODIATRY PROVIDER MANUAL

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### BENEFITS AND LIMITATIONS

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### FORMS

All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp under Pricing and Limitations.

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This is the provider-specific section of the manual. This section (Part II) was designed to provide information and instructions specific to podiatry providers. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection gives information on the billing form applicable to podiatry services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of podiatry services allowed within the Kansas Medical Assistance Program (KMAP).

**HIPAA Compliance**

As a participant in KMAP, providers are required to comply with compliance reviews and complaint investigations conducted by the secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas attorney general's office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
7000. PODIATRY BILLING INSTRUCTIONS Updated 03/12

Introduction to the CMS-1500 Claim Form
Podiatry providers must use the red CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under KMAP. An example of the CMS-1500 claim form is available:

- On the public website at https://www.kmap-state-ks.us/Public/forms.asp
- On the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp

The Kansas Medicaid Management Information System (MMIS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information must be submitted in the correct claim fields to be recognized by the equipment.

The fiscal agent does not furnish the CMS-1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the General Billing Provider Manual.

SUBMISSION OF CLAIM
Send completed first page of each claim and any necessary attachments to:
KMAP
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571
Office Visits
Use evaluation and management (E&M) procedure codes that most appropriately describe the level of services provided.
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 04/11

Podiatry services require a copayment of $1 per office visit. (Refer to Section 3000 of the General TPL Payment Provider Manual for exceptions.)

Bill all services occurring on the same date on the same claim form. Do not reduce charges or balance due by the copayment amount. This reduction will be made automatically by the fiscal agent.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.
8300. Benefit Plan Updated 04/11

KMAP beneficiaries will be assigned to one or more benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification.
BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 03/12

PODIATRY SERVICES ARE COVERED FOR KAN BE HEALTHY (KBH) BENEFICIARIES ONLY.

Adult Care Home
Podiatry services are not allowed in an adult care home (ACH), except for those services rendered to a KBH beneficiary.
One routine visit per month is covered.
No other ACH visits are covered on the same day as an ACH history and physical.

Consultations
Reasonable and medically necessary consultation services will be covered for KBH beneficiaries.

Documentation
To verify services provided in the course of a postpayment review, documentation in the beneficiary's medical record must support the service billed.

Hospital Visits
One inpatient hospital visit per day is covered.

Only one physician will be reimbursed for a patient with a single diagnosis except for consultation. When a patient has two or more diagnoses involving two or more systems where the special skill of two or more physicians are essential in rendering quality medical care, concurrent care is covered for the days when such care is medically necessary and a Certificate of Medical Necessity form (https://www.kmap-state-ks.us/Public/forms.asp) is attached.

Office Visits
One comprehensive office visit is covered per calendar year, per beneficiary.

E&M office visit procedure codes 99201 through 99205 may be used for any new patient or any patient who has not been seen by the provider within the past three years.

A new patient visit is not covered when it is within three years of any professional face-to-face service (such as E&M) or surgery service when performed by the same provider or a member of the same group with the same specialty.
Surgery

**Ambulatory/Outpatient Surgery**

Only one ambulatory/outpatient surgical procedure is reimbursed per day, per beneficiary.

**Content of Service**

IVs, medications, supplies, and injections performed on the same day as an ambulatory outpatient surgery procedure are considered content of service of the surgery and cannot be billed separately.

Anesthesia, equipment and supplies, drugs, surgical supplies, and so forth are considered content of service of the ambulatory/outpatient surgical procedure.

Procedures performed in conjunction with an emergency room visit (sutures, minor surgeries, and so forth) are considered content of service of the emergency room visit and cannot be billed separately. When reimbursement for the procedure is preferred, the *CPT*® code for the procedure performed shall be billed in lieu of the emergency room (ER) visit.

**Cosmetic Surgery**

Surgeries that are cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized. (Refer to Section 4300 of the General Special Requirements Provider Manual.)

**Elective Surgery**

The Medicaid program will not reimburse for elective surgery unless the procedure is medically necessary and the beneficiary is a KBH participant. (Refer to the *KAN Be Healthy Provider Manual* for details.)

**Global Surgery**

KMAP uses the following global surgery guidelines:

- **000** – Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; E&M services on the day of the procedure generally not payable

- **010** – Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; E&M services on the day of the procedure and during the 10-day postoperative period generally not payable

- **090** – Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount

**Physicians who furnish less than the global surgical package**

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians cannot exceed what would have been paid if a single physician provided all services. When physicians agree on a transfer of care during the global period, the following modifiers are used:

- **54** – Surgical care only
- **55** – Postoperative management only
Both the bill for the surgical care only and the bill for the postoperative care only will contain the same date of service and the same surgical procedure code with the services distinguished by the use of the appropriate modifier. If the physician who performed the surgery relinquishes care at the time of discharge, he or she needs only show the date of surgery when billing with modifier 54. However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information is reported in Item 19 on the CMS-1500 in the narrative portion of the HA0 record on the National Standard Format and in the DTP segment, Loop 2300 for ANSI X12N electronic claims.

For surgeries billed with either modifier 54 or 55, the appropriate percentage of the fee amount as indicated in Fields 17-19 of the MFSDB (pre-, intra-, and post-operative) will be paid. This applies to major surgical procedures and minor surgeries with a postoperative period of 10 days. The intraoperative percentage includes postoperative hospital visits. Split global care does not apply to procedures with a global period of “000”. It is to be assumed that a physician who bills with modifier 54 has provided pre-, intra- and post-operative hospital services. This physician should be paid the combined pre- and intra-operative portions of the fee amount.

When more than one physician bills for the postoperative care, payment should be the postoperative percentage according to the number of days each physician was responsible for the patient’s care. The Unit field on the CMS-1500 must reflect the total number of postoperative care days provided, with the cumulative total not to exceed the number of global days for the procedure being billed.

Services included in the global surgical package
E&M services are considered part of the global surgical package. No separate payment will be made for additional procedure(s) with a global surgery fee period if performed during the postoperative period of a prior procedure, by the same provider, and if billed without modifier 58, 78, or 79.

Reimbursement for return trips to the operating room during the postoperative period
When treatment for complications requires a return trip to the operating room during the postoperative period, physicians must bill the CPT® code that describes the procedure(s) performed during the return trip along with modifier 78. Payment for return trips to the operating room will be the intraoperative percent (Field 18 of the MFSDB) of the fee amount for the CPT® code.

Services not included in the global surgical package
The following services are not included in the global surgical package and may be paid for separately:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery
- Services of other physicians except where the surgeon and the other physician agree on the transfer of care
Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery

Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery

Clearly distinct surgical procedures during the postoperative period which are not reoperations or treatment for complications

*Note:* A new postoperative period begins with the subsequent procedure.

Diagnostic tests and procedures

Treatment for postoperative complications which require a return trip to the operating room

*Note:* This does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit.

If a less extensive procedure fails and a more extensive procedure is required

*Note:* The second procedure is payable.

Immunosuppressive therapy for organ transplants

Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician

Physicians must bill modifiers 24, 25, 57, 58, 78, or 79 as appropriate. Separate payment may be made for services billed with these modifiers.

Special guidelines must be followed in order for claims to process correctly using modifier 50 in conjunction with 54 or 55. Providers must bill these details with modifier 54 or 55 in the first modifier position and 50 in the second modifier position.