

Legislative Regulation Review Committee

2008-062

Department of Social Services

REQUIREMENTS FOR PAYMENT OF PODIATRIC SERVICES

R-39 REV. 04/04
IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

STATE OF CONNECTICUT
REGULATION
OF

Name of Agency

Department of Social Services

Subject Matter of Regulation

Requirements for Payment of Podiatric Services

Section 1. The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-619 to 17b-262-629, inclusive, as follows:

(NEW) Section 17b-262-619. Scope

Sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for payment of podiatric services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-620. Definitions

As used in section 17b-262-619 to section 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Acute" means symptoms that are severe and have a rapid onset and short course;
- (2) "Admission" means the formal acceptance by a hospital of a client who is to receive health care services while lodged in an area of the hospital reserved for continuous nursing services;
- (3) "Border provider" means an out-of-state provider who routinely serves clients and is deemed a border provider by the department on a provider by provider basis;
- (4) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;
- (5) "Client" means a person eligible for goods or services under the department's Medicaid program;
- (6) "Commissioner" means the Commissioner of Social Services or his or her designee;
- (7) "Consultation" means those services rendered by a podiatrist or other practitioner whose opinion or advice is requested by the client's podiatrist or other appropriate source in the evaluation or treatment of the client's illness;
- (8) "Customized item" means an item or material adapted through modification to meet the specific needs of a particular client;
- (9) "Department" means the Department of Social Services or its agent;
- (10) "Early and Periodic Screening, Diagnostic and Treatment services" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;
- (11) "Emergency" means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's

health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part;

- (12) "Freestanding clinic" means "freestanding clinic" as defined in section 171B of the department's Medical Services Policy for clinic services;
- (13) "General hospital" means "general hospital" as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies;
- (14) "Home" means the client's place of residence, including, but not limited to, a boarding home, community living arrangement or residential care home. "Home" does not include facilities such as hospitals, chronic disease hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;
- (15) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in the Medicaid program as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;
- (16) "Legend device" means "legend device" as defined in section 20-571 of the Connecticut General Statutes;
- (17) "Legend drug" means "legend drug" as defined in section 20-571 of the Connecticut General Statutes;
- (18) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;
- (19) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;
- (20) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;
- (21) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- (22) "Nursing facility" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;
- (23) "Out of state provider" means a provider that is located outside Connecticut and is not a border provider;
- (24) "Physician" means a person licensed pursuant to sections 20-8 to 20-14K, inclusive, of the Connecticut General Statutes;
- (25) "Podiatric Services" means services provided by a podiatrist within the scope of practice as defined by state law, or in title 20 of the Connecticut General Statutes;
- (26) "Podiatrist" means a doctor of podiatric medicine licensed pursuant to section 20-54 of the Connecticut General Statutes;

- (27) "Prior authorization" means approval for the provision of a service or the delivery of goods from the department before the provider actually provides the service or delivers the goods;
- (28) "Provider" means a podiatrist or a podiatrist group enrolled in Medicaid;
- (29) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standards of acceptable medical care for the condition and the client under treatment;
- (30) "Routine foot care" means clipping or trimming of normal or mycotic toenails; debridement of the toenails that do not have onychogryposis or onychiauxis; shaving, paring, cutting or removal of keratoma, tyloma or heloma; and nondefinitive shaving or paring of plantar warts except for the cauterization of plantar warts;
- (31) "Simple foot hygiene" means self-care including, but not limited to: observation and cleansing of the feet; use of skin creams to maintain skin tone of both ambulatory and bedridden patients; nail care not involving professional attention; and prevention and reduction of corns, calluses and warts by means other than cutting, surgery or instrumentation;
- (32) "Systemic condition" means the presence of a metabolic, neurologic, or peripheral vascular disease, including, but not limited to: diabetes mellitus, arteriosclerosis obliterans, Buerger's disease, chronic thrombophlebitis and peripheral neuropathies involving the feet, which would justify coverage of routine foot care;
- (33) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded; and
- (34) "Utilization review" means the evaluation of the necessity and appropriateness of medical services and procedures as defined in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-621. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-622. Eligibility

Payment for podiatric services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

(NEW) Sec. 17b-262-623. Services covered and limitations

Subject to the limitations and exclusions identified in sections 17b-262-619 to 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay providers for podiatric services provided by podiatrists:

- (1) for only for those procedures listed in the provider's fee schedule that are medically necessary and medically appropriate to treat the client's condition;

- (2) for podiatric services provided in an office, a general hospital, the client's home, a chronic disease hospital, nursing facility, ICF/MR or other medical care facility;
- (3) for laboratory services provided by a podiatrist in compliance with the provisions of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
- (4) for medical and surgical supplies used by the podiatrist in the course of treatment of a client;
- (5) for drugs and supplies administered by a podiatrist;
- (6) for a second opinion for surgery when requested voluntarily by the client or when required by the department. The department shall pay for a second opinion according to the established fees for consultation; and
- (7) for EPSDT services including, but not limited to, treatment services which are indicated following screening but not otherwise covered, provided that prior authorization is obtained.

(NEW) Sec. 17b-262-624. Services not covered

The department shall not pay a podiatrist:

- (1) for information or services provided to a client by a podiatrist over the telephone;
- (2) for any product available to podiatrists free of charge;
- (3) for more than one visit per day per client to the same podiatrist;
- (4) for cosmetic surgery;
- (5) for simplified tests requiring minimal time or equipment and employing materials nominal in cost, including, but not limited to, urine testing for glucose, albumin and blood;
- (6) for simple foot hygiene;
- (7) for repairs to devices judged by the department to be necessitated by willful or malicious abuse on the part of the client;
- (8) for repairs to devices under guarantee or warranty. The podiatrist shall first seek payment from the manufacturer;
- (9) for an office visit for the sole purpose of the client obtaining a prescription where the need for the prescription has already been determined;
- (10) for cancelled services and appointments not kept;
- (11) for services provided in a general hospital if the department determines the admission does not, or retrospectively did not, fit the department's utilization review requirements pursuant to section 17-134d-80 of the Regulations of Connecticut State Agencies; or
- (12) for any procedures or services of an unproven, educational, social, research, experimental or cosmetic nature; for any diagnostic, therapeutic or treatment services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms or medical history.

(NEW) Sec. 17b-262-625. Need for service

Payment for an initial office visit and continuing services which the department deems are medically necessary and medically appropriate, in relation to the diagnosis for which care is required, is available provided that:

- (1) the services are within the scope of the podiatrist's practice; and
- (2) the services are made part of the client's medical record.

(NEW) Sec. 17b-262-626. Prior authorization

- (a) To receive payment from the department, a podiatrist shall comply with the prior authorization requirements described in section 17b-262-528 for the Regulations of Connecticut State Agencies. The department, in its sole discretion, shall determine what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.
- (b) Prior authorization, on forms and in the manner specified by the department, shall be required for:
 - (1) physical therapy services in excess of two visits per calendar week per client per podiatrist;
 - (2) physical therapy services in excess of nine visits per calendar year per client per podiatrist, when the therapy is for the treatment of the following diagnoses:
 - (A) all mental disorders including diagnoses relating to mental retardation and specific delays in development covered by the International Classification of Diseases (ICD), as amended from time to time;
 - (B) cases involving musculoskeletal system disorders of the spine covered by the ICD, as amended from time to time; and
 - (C) cases involving symptoms related to nutrition, metabolism and development covered by the ICD, as amended from time to time;
 - (3) reconstructive surgery;
 - (4) plastic surgery;
 - (5) EPSDT services that are identified during a periodic screening as medically necessary and which are not listed on the existing fee schedule; and
 - (6) other services and supplies identified as requiring prior authorization on the fee schedule.
- (c) Prior authorization is required for payment of all hospital admissions as required and described in section 17-134d-80 of the Regulations of Connecticut State Agencies.
- (d) The authorization period shall be for a period not to exceed six months.
- (e) If prior authorization is needed beyond the initial authorization period, requests for continued treatment beyond the initial authorization period shall be considered for up to an additional six month period per request.

- (f) Except in emergency situations, prior authorization shall be received before services are rendered.
- (g) In an emergency situation that occurs after working hours or on a weekend or holiday, the podiatrist shall secure verbal prior authorization on the next working day for the services provided. This applies only to those services that normally require prior authorization.

(NEW) Sec. 17b-262-627. Billing procedures

- (a) Claims from podiatrists shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department, and shall include all information required by the department to process the claim for payment.
- (b) The amount billed to the department shall represent the podiatrist's usual and customary charge for the services delivered.
- (c) When a client is referred to a podiatrist for consultation, the consultant podiatrist shall include the referring practitioner's name.
- (d) Laboratory services performed in the podiatrist's office shall be payable to the podiatrist and shall be billed as separate line items. When a podiatrist refers a client to a private laboratory for services, the laboratory shall bill directly and no laboratory charge shall be paid to the podiatrist.
- (e) All charges billed for supplies and materials provided by a podiatrist may be reviewed by the department.
- (f) When services are provided by more than one member of a group, the authorization request shall be submitted prior to billing as described in the billing instructions in the provider manual.

(NEW) Sec. 17b-262-628. Payment

- (a) The commissioner shall establish, and may periodically update, the fees for covered services in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.
- (b) Fees shall be the same for in-state, border and out-of-state podiatrists.
- (c) Payment shall be made at the lowest of:
 - (1) the podiatrist's usual and customary charge;
 - (2) the lowest Medicare rate;
 - (3) the amount in the applicable fee schedule as published by the department pursuant to section 4-67c of the Connecticut General Statutes; or
 - (4) the amount billed by the podiatrist.
- (d) Notwithstanding the provisions of the Regulations of Connecticut State Agencies or any of the Medical Services Policies to the contrary, the department shall not pay any podiatrist under sections 17b-262-619 through 17b-262-629, inclusive, of the Regulations of Connecticut State Agencies for a client seen at a freestanding clinic enrolled in Medicaid. Only the clinic may bill for such services. As an exception to the foregoing, a podiatrist may bill for covered services for a client seen at an outpatient surgical facility. A

podiatrist who is enrolled with Medicaid at a location separate from the clinic may bill the department for clients seen at the separate practice location.

- (e) The department shall not pay interns or residents for their services nor shall the department pay for assistant surgeons in general or chronic disease hospitals staffed by interns and residents, unless the procedure is significantly complicated to justify a full surgeon acting as an assistant. If the surgery is performed by a resident or intern and the supervising surgeon assists, only the assistant's fee shall be paid to the surgeon. The regular surgical fee shall not be paid.
- (f) If a resident or intern performs the surgery and the supervising surgeon is not present while the procedure is performed, no fee shall be paid to the surgeon even when the surgeon is on call.
- (g) Payment limitations
 - (1) Fees for initial fittings and adjustments shall be included in the cost of the item or device.
 - (2) The department shall pay a podiatrist for physical therapy only if the podiatrist personally provides the physical therapy.
 - (3) Payment shall be made for a customized item for a client who dies, or is not otherwise eligible on the date of delivery, providing the client was eligible:
 - (A) on the date prior authorization was given by the department; or
 - (B) on the date the client ordered the item, if the item does not require prior authorization. For purposes of this section, the date the client orders the item means the date on which the podiatrist presents the order to the manufacturer or supplier. The podiatrist shall verify to the department the date the client ordered the item.
 - (4) The department shall pay for routine foot care only if the client has a systemic condition. Services are limited to one treatment every sixty days.
 - (5) The fees listed in the department's fee schedule shall be payable only when the services are performed by the podiatrist.
 - (6) The department shall pay for an initial visit by a podiatrist in an office, home, ICF/MR or nursing facility visit only once per client. Initial visits refer to the podiatrist's first contact with the client and reflect higher fees for the additional time required for setting up records and developing past history. The only exception to this is when the podiatrist-client relationship has been discontinued for three or more years and is then reinstated.
 - (7) Fees for consultations shall apply only when the opinions and advice of a consultant podiatrist are requested by the referring provider or other appropriate source in the evaluation and treatment of the client's illness. After the consultation is provided, the consultant shall prepare a written report of his or her findings and provide a copy of the report to the referring podiatrist or physician. In a consultation, the client's referring provider carries out the plan of care. In a referral, a second provider provides direct service to the client.
- (h) Surgery

- (1) When a claim is submitted by a podiatrist for multiple surgical procedures performed on the same date of service, the department will pay for the primary surgical procedure at the Medicaid allowed amount for podiatrists or the billed amount, whichever is lower. The department shall pay for additional surgical procedures performed on that day at fifty percent of the Medicaid allowed amount for podiatrists.
 - (2) When an assistant surgeon, in addition to staff provided by the hospital, is required, the amount payable by the department to the assistant surgeon shall be as indicated on the fee schedule.
 - (3) Subsequent to the decision for surgery, fees for surgical procedures include one related evaluation and management encounter on the date immediately prior to, or on, the date of the procedure, including history and physical.
 - (4) The listed fees for all surgical procedures include the surgery and typical postoperative follow-up care while in the general or chronic disease hospital. Follow-up visits related to the surgery shall not be payable as office visits.
 - (5) The listed fees for surgery on the musculoskeletal system shall include payment for the application of the first cast or traction device.
- (i) Radiology
- (1) The listed fees for all diagnostic radiology procedures shall include consultation and a written report to the referring provider.
 - (2) The listed fees for all diagnostic radiology procedures shall apply only when the podiatrist's own equipment is being used. If the equipment used to perform the procedure is owned directly or indirectly by the general or chronic disease hospital or a related entity, or if a hospital includes the operating expenses of the equipment in its cost reports, the podiatrist shall not be paid for the technical component of the listed fee.
- (j) Laboratory
- (1) The following routine laboratory tests shall be included in the fee for an office visit and shall not be payable on the same date of service: urinalysis without microscopy, hemoglobin determination and urine glucose determination.
 - (2) No payment shall be made for tests which are provided free of charge.
 - (3) Payment shall be made for panel or profile tests according to the fees listed in the department's fee schedule for panel tests and not according to the fee for each separate test included in the panel or profile.
- (k) Drugs
- (1) The department shall pay the actual acquisition costs for oral medications incident to an office visit as billed by the podiatrist.
 - (2) The department shall pay for legend drugs and legend devices administered by the podiatrist based on a fee schedule determined by the department.
 - (3) No payment shall be made for drugs provided free of charge.
- (l) Admission to a general hospital

Payment for services provided by the admitting podiatrist in a general hospital shall not be made available if it is determined by the department's utilization review program, either prospectively or retrospectively, that the admission did not fulfill the accepted professional criteria for medical necessity, medical appropriateness, appropriateness of setting or quality of care. Specific requirements are described in section 17-134d-80 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-629. Documentation and audit requirements

- (a) Podiatrists shall maintain a specific record for all services received by each client eligible for Medicaid payment including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current treatment plan and treatment notes signed by the podiatrist, documentation of services provided and the dates the services were provided and a signed receipt for all devices dispensed. The receipt for dispensed device, regardless of the format used, shall, at a minimum, contain the following elements:
- (1) the podiatrist's name;
 - (2) the client's name;
 - (3) the delivery address;
 - (4) the date of delivery; and
 - (5) itemization of the device delivered, including:
 - (A) a product description;
 - (B) a brand name;
 - (C) a model name and number, if applicable;
 - (D) a serial number, if applicable;
 - (E) the quantity delivered; and
 - (F) the amount billed per device.
- (b) All required documentation shall be maintained in its original form for at least five years or longer by the podiatrist in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.
- (c) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the podiatrist for which the required documentation is not maintained and not provided to the department upon request.
- (d) The department retains the right to audit any and all relevant records and documentation and to take any other appropriate quality assurance measures it deems necessary to assure compliance with these and other regulatory and statutory requirements.
- (e) Podiatrists shall maintain documentation supporting all prior authorization requests.

Section 2.

Repealer

Sections 179 through 179 I.II.b., inclusive, of the department's Medical Services Policy for podiatric services, which have the force of regulation pursuant to section 17b-10 of the Connecticut General Statutes, are repealed.

REGULATION

OF

IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Coverage of Podiatry Services

SECTION _____

Statement of Purpose: The proposed regulation updates a Medical Services Policy that was last revised in the 1980s and adopts the podiatry policy in regulation format. (A) The purpose of the regulations is to set forth in regulation form the requirements under which podiatrists who are enrolled in the Connecticut Medical Assistance Program (Medicaid) are to provide services in order to receive reimbursement pursuant to section 17b-262 of the Connecticut General Statutes. The problems, issues or circumstances that the regulation proposes to address are: (1) to incorporate current policy and practice; (2) to modify service limitations to mirror the limits in the physician regulation and fee schedule; (3) to clarify the prior authorization process, documentation requirements, and the billing procedures; (4) to add necessary definitions; (5) to adopt the policy in regulation format; and (6) to make technical changes.

(B) The main provisions of the regulation are: (1) the establishment of the requirements under which a provider can enroll in Medicaid; (2) to indicate that reimbursement for provider services are limited to those services that are provided to Medicaid eligible persons; (3) to define services covered and limitations, specifically citing the department's fee schedule for podiatrists for procedures that are medically necessary and appropriate; (4) to specify services that are not covered by Medicaid; (5) to indicate which podiatrist services require prior authorization; (6) to outline billing procedures; (7) to indicate payment procedures, rates, and limitations; and (8) to reference necessary documentation and audit requirements.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws are: the regulation repeals sections 179 through 179I.II.b, inclusive, of the Department's Medical Services Policy for podiatric services, which have the force of regulation pursuant to Section 17b-10 of the Connecticut General Statutes.

CERTIFICATION

R-39 REV. 1/77

Be it known that the foregoing:

Page 2 of 2 pages

Regulations Emergency Regulations

Are:

Adopted Amended as hereinabove stated Repealed

By the aforesaid agency pursuant to:

Sections 17b-262 of the General Statutes.

Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on April 15, 2008, of the notice of the proposal to:

Adopt Amend Repeal such regulations

(If applicable): And the holding of an advertised public hearing on June 2 day of 2008

WHEREFORE, the foregoing regulations are hereby:

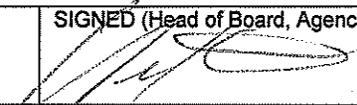
Adopted Amended as hereinabove stated Repealed

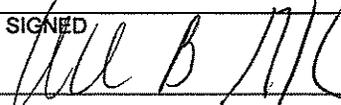
Effective:

When filed with the Secretary of the State.

(OR)

The _____ day of _____

In Witness Whereof:	Date	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED
	<u>7/31/08</u>		Commissioner

Approved by the Attorney General as to legal sufficiency accordance with sec. 4-169, as amended C.G.S.	SIGNED	OFFICIAL TITLE, DULY AUTHORIZED
	 <u>9/19/08</u>	ASSOC. ATTY. GENERAL

- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice

By the Legislative Regulation Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes.	Date	SIGNED (Clerk of the Legislative Regulation Review Committee)

Two certified copies received and filed, and one such copy forwarded to the Commission in Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY

INSTRUCTIONS

- One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
- Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
- Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
- Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.