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TO: **Arkansas Medicaid Health Care Providers - Podiatrists**

DATE: **March 15, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 51**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000 – 201.300	Dates Vary	201.100 – 201.400	3-15-05
202.000	10-13-03	202.000	3-15-05
242.100 – 242.120	Dates Vary	242.100 – 242.120	3-15-05

Explanation of Updates

The following changes will be effective on and after March 15, 2005.

Section 201.100 is the former section 201.000. It has been renamed. The section sets forth the current requirements for participation in the Arkansas Medicaid Podiatry Program.

Section 201.200 is the former section 201.100. This section is included to explain the purpose of and procedures for enrolling as a group provider in the Arkansas Medicaid Program.

Sections 201.300 and 201.400 are the former sections 201.200 and 201.300, respectively.

Section 202.000 is included to explain that podiatrists are not required to participate in the Title XVIII (Medicare) Program in order to participate in the Medicaid Program.

Section 242.100 has been updated to add new procedure codes as part of the podiatrist services. The new services allow podiatrists to perform surgery on the ankle. Also, other procedure codes that had previously been omitted have been added to this section. An asterisk has been placed on codes that have a special requirement and an explanation has been placed in this section.

Section 242.110 has been updated to include procedure codes that were previously omitted. Special information regarding a procedure code in this section has an asterisk attached to it, and the information is outlined at the bottom of this section.

Section 242.120 has been updated to include more procedure codes that require prior authorization and that were previously omitted from the manual.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

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Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

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201.100 Participation Requirements for Individual Podiatrists 3-15-05

Podiatrists must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program.

A. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

B. The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

C. The provider must be licensed to practice podiatrist's services in his or her state.

1. A copy of the current state license must accompany the provider application and Medicaid contract.
2. A copy of subsequent state licensure renewal must be forwarded to Provider enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional final 30 days to comply.
3. Failure to timely submit verification of license renewal will result in termination of enrollment in the Arkansas Medicaid Program.

D. The provider must submit Clinical Laboratory Improvement Amendments (CLIA) certification, if applicable. (Section 205.000 contains information regarding CLIA certification.)

201.200 Group Providers of Podiatrists' Services 3-15-05

Group providers of podiatric services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

A. In order for a group of podiatrists to have Arkansas Medicaid reimburse the group for the services of its members, the group and the individual podiatrist must enroll in Arkansas Medicaid.

1. Each podiatrist member of the group who intends to treat Medicaid recipients must enroll in accordance with the requirements in section 201.100.
2. The group must also enroll in the Arkansas Medicaid Program by completing and submitting to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).

   The Arkansas Medicaid Program must approve the provider application and the Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid Providers.

B. All group providers are "pay to" providers only. The service must be performed and billed by the performing licensed and enrolled podiatrist with the group.

201.300 Podiatrists in Arkansas and Bordering States 3-15-05

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Podiatrists in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in Section 201.100.

Routine Services Providers

A. Routine services providers may be enrolled in the program as providers of routine services.

B. Reimbursement may be available for all podiatrist services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to Section II of this manual. This includes assignment of ICD-9-CM and HCPCS codes for all services rendered.

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201.400 Podiatrists in Non-Bordering States 3-15-05

Podiatrists in non-bordering states may be enrolled only as limited services providers.

Limited Services Providers

Limited services providers may be enrolled in the program to provide “emergency” or “prior authorized” services only.

Emergency services are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

Prior authorized services are those services that are medically necessary and not available in Arkansas. Each request for these services must be made in writing and mailed to the Arkansas Division of Medical Services, Utilization Review Section and approved before the service is provided. **View or print the Arkansas Division of Medical Services, Utilization Review Section contact information.** An Arkansas Medicaid contract must be signed before reimbursement can be made

Limited services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Arkansas Division of Medical Services Program Communications Section. **View or print the Arkansas Division of Medical Services Program Communications Section contact information.**

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202.000 Optional Enrollment in the Title XVIII (Medicare Program) 3-15-05

Podiatrists have the option of enrolling in the Title XVIII (Medicare) Program in order to be eligible for participation in the Arkansas Medicaid Program as providers of podiatrist’s services. When a recipient is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse for those services if Medicare has not been billed prior to Medicaid billing. The recipient cannot be billed for the charges. Claims filed by Medicare “non-participating” providers do not automatically cross over to Medicaid for payment of deductibles and coinsurance.

NOTE: The podiatrist provider must notify the Provider Enrollment Unit of a Medicare provider number. View or print Provider Enrollment Unit contact information.

242.100 Procedure Codes 3-15-05

The following list of procedure codes must be used to bill for a podiatrist's services. Several procedure codes from the list below are payable only in situations described in separate sections.

A. Procedure codes that must be billed when services are provided in a nursing home or in a skilled nursing facility are located in section 242.110.

B. Procedure codes requiring prior authorization before services may be provided are located in section 242.120.

C. Procedure codes payable to podiatrists for laboratory and X-ray services are located in section 242.130.

D. Procedure code **99238**, Hospital Discharge Day Management, may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes **99221** through **99233**). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

E. In addition to the CPT codes shown below, **T1015**, an HCPCS code, is payable to podiatrists.

F. Procedure codes **99353** and **Q0182** must be billed for services provided in the recipient's home. See section 242.110 for additional information regarding code **Q0182**.

The listed procedure codes and their descriptions are located in the *Physician's Current Procedural Terminology (CPT)* book. Section III of the Podiatrist Manual contains information on how to purchase a copy of the CPT publication.

Procedure Codes							
J7340	Q0182	10060	10061	10120	10140	10160	10180
11000	11040	11041	11042	11043	11044	11055	11056
11057	11100	11200	11201	11420	11421	11422	11423
11424	11426	11620	11621	11622	11623	11624	11626
11719	11720	11721	11730	11732	11740	11750	11752
11760	11762	12001	12002	12004	12020	12021	12041
12042	12044	13102	13122	13131	13132	13153	13160
14040	14350	15000	15001	15050	15100	15101	15120
15121	15220	15221	15240	15241	15342	15343	15620
15999	16000	16010	16015	17000	17003	17004	17110
17111	17999	20000	20005	20200	20205	20206	20220
20225	20240	20500	20501	20520	20525	20550	20551
20552	20553	20600	20605	20612	20615	20650	20670
20680	20690	20692	20693	20694	20900	20910	20974
20975	27605	27606	27610	27612	27620	27625	27626
27648	27650	27654	27687	27690	27695	27696	27698
27700	27702	27703	27704	27792	27808	27810	27814

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27816	27818	27822	27823	27840	27842	27846	27848
27860	27870	27888	27889	28001	28002	28003	28005
28008	28010	28011	28020	28022	28024	28030	28035
28043	28045	28046	28050	28052	28054	28060	28062
28070	28072	28080	28086	28088	28090	28092	28100
28102	28103	28104	28106	28107	28108	28110	28111
28112	28113	28114	28116	28118	28119	28120	28122
28124	28126	28130	28140	28150	28153	28160	28171
28173	28175	28190	28192	28193	28200	28202	28208
28210	28220	28222	28225	28226	28230	28232	28234
28238	28240	28250	28260	28261	28262	28264	28270
28272	28280	28285	28286	28288	28290	28292	28293
28294	28296	28297	28298	28299	28300	28302	28304
28305	28306	28307	28308	28310	28312	28313	28315
28320	28322	28340	28341	28344	28345	28360	28400
28405	28406	28415	28420	28430	28435	28436	28445
28450	28455	28456	28465	28470	28475	28476	28485
28490	28495	28496	28505	28510	28515	28525	28530
28540	28545	28546	28555	28570	28575	28576	28585
28600	28605	28606	28615	28630	28635	28645	28660
28665	28666	28675	28705	28715	28725	28730	28735
28737	28740	28750	28755	28760	28800	28805	28810
28820	28825	28899	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520
29540	29550	29580	29750	29893	29894	29895	29897
29898	29899	29999*	64450	64550	64704	64782	73592
73600	73610	73615	73620	73630	73650	73660	82962
87070	87101	87102	87106	87184	93922	93923	93924
93925	93926	93930	93931	93965	93970	93971	95831
95851	99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99221	99222	99223	99231	99232
99233	99238	99241	99242	99243	99244	99245	99251
99252	99253	99254	99255	99271	99272	99273	99281
99282	99283	99284	99301	99302	99303	99341	99342
99343	99347	99348	99349	99353			

*Code **29999** is manually priced.

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The following procedure codes must be billed when services are provided in a nursing care facility.

Q0182*	10060	10061	10120	10160	10180	11040	11055
11056	11057	11200	11201	11420	11421	11422	11423
11424	11426	11720	11721	11730	11732	11740	11750
12001	12020	12021	12041	16000	20550	20551	20552
20553	20612	28190	28630	28660	82962	87070	87102

*Code **Q0182** requires prior authorization when billed for a nursing home service.

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242.120 Procedure Codes Requiring Prior Authorization 3-15-05

The following codes require prior authorization before services may be provided.

J7340	Q0182	15342*	15343*	20974	20975

*Effective for dates of service on and after October 1, 2004, CPT procedure codes **15342** and **15343** do not require prior authorization when the diagnosis is burn injury (ICD-9-CM code range 940.0 through 949.5). All other diagnoses requiring the use of these procedures will continue to require prior authorization.

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