Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – Podiatrist**

DATE: **January 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #60**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100 – 201.200	3-15-05	201.100 – 201.200	1-1-06
214.000	10-13-03	214.000	1-1-06
215.100	10-13-03	215.100 – 215.130	1-1-06
242.100	11-1-05	242.100	1-1-06
242.440	1-15-05	242.440	1-1-06

Explanation of Updates

Sections 201.100 through 201.200: The provider participation and enrollment requirements process has been updated.

Section 214.000: The information in this section has been reworded.

Section 215.100: The title of this section has been changed to "Procedure for Obtaining Extension of Benefits for Podiatry Services". The information in this section has been updated and outlines the new process for requesting extension of benefits. Providers are advised that a request for extension of benefits for podiatry services must be submitted on form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services.

Section 215.110: This is a new section titled "Administrative Reconsideration of Extension of Benefits Denial" that outlines the process for providers to request another review of their initial extension of benefits request.

Section 215.115: This is a new section titled "Documentation Requirements". It outlines the type of documentation that should be submitted with extension requests.

Section 215.130: This is a new section titled "Appealing an Adverse Action". This section refers providers to the section of the manual regarding the administrative appeals process.

Section 242.100: The procedure codes table in this section has been updated to inform providers that procedure codes 15999, 17999 and 29999 are manually priced. An explanation has been placed at the end of the section specifying the manual pricing requirements related to these codes. Also, procedure code **T1015** had previously been omitted from this table, but it has been added with this update.

Section 242.440: The information in this section has been reworded.

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 have already been incorporated.

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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II - PODIATRIST

CONTENTS

200.000 PODIATRIST GENERAL INFORMATION 10-13-03

201.000 Arkansas Medicaid Participation Requirements for Podiatrists 3-15-05

201.100 Participation Requirements for Individual Podiatrists 1-1-06

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. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. 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 the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and 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 1-1-06

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 beneficiaries 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).
3. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. 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.

214.000 Benefit Limits 1-1-06

Medicaid-eligible patients are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) contractor authorizes an extension of a particular benefit. If a Medicaid-eligible patient elects to receive a service for which DMS contractor has denied a benefit extension or for which DMS contractor subsequently denies a benefit extension, the patient is responsible for payment. **View or print the AFMC contact information.**

215.100 Procedure for Obtaining Extension of Benefits for Podiatry Services 1-1-06

A. Requests for extension of benefits for podiatry services for beneficiaries under age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). **View or print the Arkansas Foundation for Medical Care, Inc., contact information.** A request for extension of benefits must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extension of benefits are considered only after a claim is denied because the patient's benefit limits are exhausted.
2. The request for extension of benefits must be received by AFMC within 90 calendar days of the date of the benefits-exhausted denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exhausted denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
4. AFMC will not accept extension of benefits requests sent via electronic facsimile (FAX).

B. Use form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services, to request extension of benefits for podiatry services. **View or print form DMS-671.** Consideration of requests for extension of benefits requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider's signature (with his or her credentials) and the date of the request are required on the form. Stamped or electronic signatures are accepted. All applicable records that support the medical necessity of the extended benefits request should be attached.

C. AFMC will approve or deny an extension of benefits request – or ask for additional information – within 30 calendar days of their receiving the request. AFMC reviewers will simultaneously advise the provider and the beneficiary when a request is denied.

215.110 Administrative Reconsideration of Extension of Benefits Denial 1-1-06

A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to 215.115.

The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.

215.115 Documentation Requirements 1-1-06

A. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

B. Documentation requirements are as follows.

1. Clinical records must:
   a. Be legible and include records supporting the specific request
   b. Be signed by the performing provider
   c. Include clinical, outpatient and/or emergency room records for dates of service in chronological order
   d. Include related diabetic and blood pressure flow sheets

e. Include current medication list for date of service

f. Include obstetrical record related to current pregnancy

g. Include clinical indication for laboratory and x-ray services ordered with a copy of orders for laboratory and x-ray services signed by the physician

2. Laboratory and radiology reports must include:

a. Clinical indication for laboratory and x-ray services ordered

b. Signed orders for laboratory and radiology services

c. Results signed by performing provider

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests

215.130 Appealing an Adverse Action 1-1-06

Please see section 190.000 *et al.* for information regarding administrative appeals.

242.100 Procedure Codes 1-1-06

Sections 242.100 through 242.120 list the procedure codes payable to podiatrists. Any special billing or other requirements are described in parts A through F of this section and in sections 242.110 and 242.120.

A. Procedure codes for podiatry services provided in a nursing home or skilled nursing facility are listed in section 242.110.

B. Procedure codes for podiatry services requiring prior authorization are listed 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**, a HCPCS code, is payable to podiatrists.

F. Procedure code **99353** must be billed for a service provided in a beneficiary's home.

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	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	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	T1015			

*Procedure codes **15999**, **17999** and **29999** are manually priced and require an operative report.

242.440 Bilaminate Graft or Skin Substitute Procedures 1-1-06

Arkansas Medicaid reimburses podiatrists who furnish the manufactured viable bilaminate graft or skin substitute. The product is manually priced and requires paper claims using procedure code **J7340**, type of service code 1. The manufacturer's invoice and the operative report must be attached.

Application procedures of bilaminate skin substitute are payable to the podiatrist using procedure codes **15342** and **15343**. These codes must be listed separately when filing claims. 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 procedure codes will continue to require prior authorization.

Surgical preparation procedures using procedure codes **15000** and **15001** may be reimbursed when performed at the same surgical setting. These codes must be listed separately in addition to the primary procedure and do not require PA.