MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 21, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600– PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600 – Physician Services are being proposed to expand coverage of Podiatry Services as authorized during the 2017 Legislative session. Podiatry services are being expanded to include coverage for all Medicaid eligible individuals.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type 21 – Podiatry.

Financial Impact on Local Government: none known.

These changes are effective January 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31439 Physician Services	MTL 25/15 Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.7	**Podiatry**	Language removed and edited to remove reference to limitation of services, added language to defining podiatry services.
603.7A	**Prior Authorization**	Changed name of section to include Limitations. Deleted Healthy Kids reference, renumbered policy limitations and added language to references for radiology, laboratory, prescription of drugs and telehealth services.
603.7B	**Covered Services**	Added section to outline reimbursable services that are covered by podiatry services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.7C	**Non-Covered Services**	Revised section to Non-Covered Services indicating that routine preventive care and preventive services were added as non-covered services.

Services are limited to Medicaid eligible children under 21 years of age and Qualified Medicare Beneficiaries (QMB's).

A. Prior authorization is not required for:

1. Four or less chiropractic office visits (emergent or non-emergent) for children under 21 years of age in a rolling 365 days. The visits must be as a direct result of an EPSDT screening examination, diagnosing acute spinal subluxation.

2. Chiropractic services provided to a QMB recipient.

B. Prior authorization is required for:

Chiropractic visits for children under 21 years of age whose treatment exceeds the four visits. The physician must contact the Nevada Medicaid QIO-like vendor for prior authorization.

603.7 PODIATRY

Podiatry services are rendered by a medical specialist who has received the degree of Doctor of Podiatry Medicine (D.P.M.) from an accredited school of podiatry, has passed the examination given by the National Board of Podiatric Medical Examiners and is licensed through the Nevada State Board of Podiatry (in accordance to NRS 635.050). Podiatrists are medical specialists who~~those services provided by health professionals trained to~~ diagnose, ~~and~~ treat and care for: injury, disease~~s and~~ or other ~~disorders~~medical conditions affecting the foot, ankle and structure of the leg.~~ of the feet. A p~~Podiatrists performs surgical procedures and prescribe~~s~~ corrective devices, medications and physical therapy.~~ For Nevada Medicaid recipient's podiatric services are limited to QMB recipients and Medicaid eligible children referred as the result of a Healthy Kids (EPSDT) screening examination.~~

A. Prior Authorization and Limitations

~~1. Prior authorization is not required for podiatric office visits provided for children as a direct result of a Healthy Kids (EPSDT) screening examination).~~

~~2.~~1. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.

~~3.~~2. Prior authorization is not required for Podiatry services provided to a QMB or QMB/MED recipient. Medicaid automatically pays the co-insurance and deductible up to Medicaid's maximum reimbursement after Medicare pays. If Medicare denies the claim, Medicaid will also deny payment.

3. Radiology Service

a. Radiology services are covered when deemed medically necessary; refer to MSM Chapter 300, Radiology Services for services and prior authorization requirements.

4. Laboratory Services

a. Laboratory services are covered when deemed medically necessary; refer to MSM Chapter 800, Laboratory Services for services and prior authorization requirements.

5. Prescription of Drugs

a. Prescription of drugs are covered when deemed medically necessary; refer to MSM Chapter 1200, Prescribed Drugs for services and prior authorization requirements.

6. Telehealth Services

a. Telehealth services are covered when deemed medically necessary; refer to MSM Chapter 3400, Telehealth Services for services and prior authorization requirements.

B. Covered Services

1. Evaluation and Management Services

a. Evaluations, examinations, consultations, treatments, health supervision.
b. Office visits, home visits, hospital visits, emergency room visits, nursing home visits.

2. Surgical Procedures

a. Multiple surgeries
b. Mycotic procedures
c. Casting/strapping/tapping

i. These procedures are covered when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains and open wounds (related to podiatrist's scope of practice) and require prior authorization.

3. Infection and Inflammation Services

a. Trimming of nails, cutting or removal of corns and calluses are allowed if either infection or inflammation is present.

~~B.~~C. Non-~~-~~Covered Services

1. Preventive care including the cleaning and soaking of feet~~,~~ and the application of creams to insure skin tone.~~, and~~

2. ~~r~~Routine foot care in the absence of infection or inflammation.~~are not covered benefits.~~ Routine foot care includes the trimming of nails, cutting or removal of corns and calluses ~~in the absence of infection or inflammation.~~

a. Preventive care and routine foot care can be provided by Outpatient Hospitals, APRN, M.D., D.O. and PA/PA-C.

603.8 PHYSICIAN SERVICES PROVIDED IN RURAL HEALTH CLINICS

A. Rural Health Clinic (RHC)

1. Medicaid covered outpatient services provided in RHCs are reimbursed at an all-inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day.

This all-inclusive rate includes any one or more of the following services and medical professionals:

a. Physician (MD/DO);

b. Dentist;

c. Advance Practice Registered Nurse (APRN);

d. Physician Assistant (PA/PA-C);

e. Certified Registered Nurse Anesthetist (CRNA);