

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.01</b>	
	<b>Pages: 1</b>	
<b>Subject: Introduction</b>	<b>Cross Reference:</b>	

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.02</b>	
	<b>Pages: 1</b>	
<b>Subject: Anesthesia</b>	<b>Cross Reference:</b>	

Local infiltration, metacarpal/ metatarsal/ digital blocks, or topical anesthesia are covered in the allowance for the specific surgical procedure. The provider must not bill separately for these types of anesthesia procedures.

If IV sedation is used, the provider may bill for the cost of the drug by billing the appropriate HCPCS code. The name of the drug, the strength, route of administration, and the dosage must be documented in the medical record. The amount entered in the "Charge" column of the CMS-1500 claim form must reflect the physician's actual cost for the drug.

For billing claims for unspecified drugs or procedures, the unspecified code should be used only if a more specific code is unavailable.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.03</b>	
	<b>Pages: 3</b>	
<b>Subject: Documentation</b>	<b>Cross Reference: Maintenance of Records 7.03</b>	
	<b>Routine Foot Care/ Systemic Conditions 42.09</b>	

All claims are subject to periodic prepayment and post payment review to assure covered program payments are made for foot care services. Providers must maintain proper and complete documentation to verify the services provided and the medical necessity for the services. Pre-printed standard forms, operative reports, and letters are not acceptable.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and those paid for by Medicaid, foot care providers must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

- Date(s) of service
- Patient's presenting complaint(s)
- Patient's history and physical findings
- Treatment rendered, including: frequency of treatment, proposed length of treatment, and progress reports documenting the patient's progress with the treatment, and prognosis
- Diagnosis(es) to substantiate all treatments/procedures
- The name, strength, dosage, route (intramuscular, intravenous, subcutaneous, oral, topical, etc.), date and time, indication for, and the administration of all medications administered to the patient
- Patient's or guardian's refusal of services, if applicable
- Photographs, if applicable, must be prints, not slides, and include the patient's name and date of service
- Description(s) of wound(s), ulcer(s), etc., if applicable, including size, appearance, and location for each date of service billed
- Foot care provider's signature

The following information is offered as helpful information regarding documentation, but it is not intended to be comprehensive. The provider has full responsibility for maintaining complete medical records and documentation to justify the medical necessity and services provided.

Refer to General Policy, section 7.0 for additional documentation requirements.

**Photographs**

When appropriate to supplement documentation, providers are encouraged to utilize and maintain photographs in their medical record for documentation requirements. The name of the patient and the date of the photograph must be marked on each photograph. The following are a few examples where clinical photographs may be helpful as supporting documentation.

- To document severe paronychia cases where nails have to be repeatedly avulsed due to

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persistent/recurrent infections or where multiple nails have to be avulsed.

- To document clinical evidence of systemic conditions related to the foot.
- To document mycotic nails.
- To document the severity of ulcers of the foot as well as progress in treating the ulcers.
- To document deformities such as hammertoe.
- To document traumatic injuries.
- To document severity of ingrown great toenails or to document an ingrown toenail condition on toes other than the big toe.

### **Narrative/Operative Report**

The provider must maintain a narrative or operative report specific for the patient and procedure. A standard form report is not acceptable. The report must fully document the procedure and the type of anesthesia used for the procedure.

### **Clinical Evidence**

The provider must fully document the clinical evidence for all conditions.

### **ICD-9 Codes**

ICD-9 codes must be used to document all conditions on the CMS-1500 claim form. It is recommended that the codes be added to the documentation in the medical record file.

### **Modifiers**

When billing a claim, the following modifiers should be used with the HCPCS and CPT codes and identified on the CMS-1500 claim form.

- TA – Left foot, great toe
- T1 – Left foot, second digit
- T2 – Left foot, third digit
- T3 – Left foot, fourth digit
- T4 – Left foot, fifth digit
- T5 – Right foot, Great toe
- T6 – Right foot, second digit
- T7 – Right foot, third digit
- T8 – Right foot, fourth digit

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- T9 – Right foot, fifth digit

#### **Foot Care Modifiers for Systemic Conditions**

- Q7 - One Class A finding
- Q8 – Two Class B findings
- Q9 – One Class B and two Class C findings

For foot care performed on a beneficiary with a systemic condition, see Section 42.09 Routine Foot Care/Systemic Condition of this manual.

#### **Injections**

The name of the drug, the strength, route of administration, and the dosage must be documented in the medical record.

#### **Office Visits**

The documentation in the medical record must be complete enough to identify the specific level of visit.

#### **Radiology**

X-ray reports must be available on all x-rays.

#### **Recurrent/Persistent Infection/Conditions**

The full name and address of the MD/DO treating the patient for a systemic condition must be documented, along with the last date that the patient was seen by the MD/DO. It is important to document this information accurately because prepayment and post payment verification are done separately.

For routine foot care required as a result of or associated with systemic conditions, the medical record must include full documentation of the clinical symptoms of the systemic condition.

#### **Warts**

The medical record must document the site of each wart, the size of each, and the method of treatment or surgical removal.

#### **Physical Therapy**

The medical record must document the medical necessity for the therapy, the specific modality or procedure, the frequency of the therapy, the proposed length of therapy, and progress reports documenting the patient's progress with the therapy.

In addition to providing appropriate information on the CMS-1500 claim form, it is the responsibility of the provider to retain the complete documentation in the medical record and to make such documentation available upon request by the Mississippi Medicaid program.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.04</b>	
	<b>Pages: 1</b>	
<b>Subject: Injections</b>	<b>Cross Reference:</b>	

**Injections**

For injections into a foot joint or bursae, the provider may bill CPT codes 20600 or 20605. Do not use CPT code 64450 for injections into a foot joint or bursae.

For injections into a tendon sheath, ligament, neuroma, or ganglion cyst, the provider may bill the CPT code 20550. Do not use CPT code 64450 for injections into a tendon sheath, ligament, neuroma, or ganglion cyst.

For Medicaid covered injectable drugs, the provider must use the HCPCS procedure codes. The amount entered in the "charge" column must reflect the physician's actual cost for the drug.

Local infiltration, digital blocks, or topical anesthesia are covered in the allowance for the specific surgical procedure. The provider must not bill separately for these type anesthesia procedures.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.05</b>	
	<b>Pages: 1</b>	
<b>Subject: Laboratory</b>	<b>Cross Reference: Laboratory 37.0</b>	

**Laboratory**

Laboratory services such as SMA or other chemistry profiles, blood sugars, urinalysis, etc., may be required for care of a systemic condition. These tests are payable only to the MD/DO supervising the systemic condition or to a laboratory to which the MD/DO has referred the specimen. Laboratory services performed by the DPM (Doctor of Podiatric Medicine) or referred to an independent laboratory by the DPM are not covered under the Mississippi Medicaid program. Refer to section 37.0, Laboratory for additional policy .

Identification of culture of fungi in the toenail clippings is not covered.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.06</b>	
	<b>Pages: 1</b>	
<b>Subject: Physical Therapy</b>	<b>Cross Reference:</b>	

CPT Codes 97010 through 97139 identify Physical Therapy Modalities. Only those that are medically necessary and appropriate for treatment of a foot condition are covered. Pre-certification is required by the Division of Medicaid for certain physical therapy procedures. Providers must pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Services performed for conditions "above the ankle" are not covered unless within the scope of the provider's licensure.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.07</b>	
	<b>Pages: 1</b>	
<b>Subject: Radiology</b>	<b>Cross Reference:</b>	

When medically necessary, radiology services are provided in an office setting. It is understood that the provider is providing both the technical and professional components of the service. Medicaid will reimburse the provider the appropriate Medicaid fee or the submitted charge, whichever is the lesser. Reimbursement will be a fee that includes both technical and professional components.

If the provider does not provide the technical component and is billing for the professional component only, **MODIFIER -26 MUST BE USED TO IDENTIFY THE PROFESSIONAL COMPONENT.**

Example: 73620-26

The provider must file for the radiology service under the appropriate CPT code. The most common codes used for diagnostic radiology for the foot are within the CPT code range 73600 through 73660

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.08</b>	
	<b>Pages: 1</b>	
<b>Subject: Routine Foot Care</b>	<b>Cross Reference: Routine Foot Care/Systemic Conditions 42.09</b>	

Routine foot care is defined as the cutting or removal of corns, calluses, and/or trimming of nails (including mycotic nails), and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

**Routine foot care is not covered under the Mississippi Medicaid program.** Services that normally are considered routine and not covered include the following:

- The cutting or removal of corns and calluses.
- The trimming of nails, including the cutting, clipping, or debridement of ingrown toenails, club nails, or mycotic nails.
- Fungal infections of the nail plates or mycotic nails are common disorders that increase in prevalence with age. A variety of fungal infections produce little or no symptomatology beyond white opacities on the nail. Treatment of this type of fungal infection is considered routine foot care.
- Avulsing small chips after trimming of the thickened/elongated nails that may have been painful, under the diagnosis of ingrown toenail, is considered equivalent to routine foot care.
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury or symptoms involving the foot.
- Foot care such as routine soaking and application of topical medication per a physician's order between required visits to the physician is considered routine foot care.

**For routine foot care performed on a beneficiary with a systemic condition, see Section 42.09 Routine Foot Care/Systemic Conditions in this manual.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.09</b>	
	<b>Pages: 3</b>	
<b>Subject: Routine Foot Care/Systemic Conditions</b>	<b>Cross Reference: Routine Foot Care 42.08</b>	

The definition/coverage of Routine Foot Care is addressed in Section 42.08.

Routine foot care procedures may pose a hazard when performed by a nonprofessional person on patients with a systemic condition that has resulted in severe circulatory compromise or areas of desensitization in the legs or feet. The presence of metabolic, peripheral, or neurological disease may require scrupulous foot care by a professional that is considered routine in the absence of systemic conditions.

These foot care procedures, when performed for these conditions, are covered under the Mississippi Medicaid Program.

Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular conditions (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care.

- Diabetes Mellitus
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangitis obliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet that are associated with malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), or pernicious anemia
- Peripheral neuropathies involving the feet that are associated with:
  - carcinoma
  - diabetes mellitus
  - drugs and toxins
  - multiple sclerosis
  - uremia (chronic renal disease)
  - traumatic injury
  - leprosy
  - neurosyphilis
  - hereditary disorders
  - hereditary sensory radicular neuropathy
  - angiokeratoma corporis diffusum (Fabry's)
  - amyloid neuropathy
  - anticoagulant therapy for any reason

For the above conditions, the patient must be under the active care of an MD/DO for such condition to qualify for covered routine foot care. The active care requirement will be satisfied if the patient has been seen by the attending physician for the condition within the previous six-month period.

The provider must indicate the full name and degree of the treating physician (MD or DO) in item 17 on the CMS-1500 claim form, and the month and year of the last visit in Item 19 on the CMS-1500 claim form. This must also be documented in the medical records. Periodic validation will be made with the treating physician (MD or DO).

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Medical necessity must be documented by use of proper ICD-9 diagnosis coding. In those patients who have an underlying systemic condition and the localized pathology of the foot requires professional intervention, identify these complicating factors by the use of ICD-9 codes. Documentation of the systemic condition with the severity of its clinical symptoms must be provided on each claim. A mere statement of diagnosis, such as Diabetes, does not, in itself, indicate the severity of the condition.

The following criteria may be helpful to the provider in documenting sufficient clinical evidence.

### **Class A Findings**

- Non-traumatic amputation of foot or integral skeletal portion thereof.

### **Class B Findings**

- Absent posterior tibial pulse;
- Three of these advanced trophic changes: hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), skin color (rubor or redness); and
- Absent dorsalis pedis pulse.

### **Class C Findings**

- Claudication;
- Temperature changes (cold feet);
- Edema;
- Paresthesia (abnormal spontaneous sensation in the feet); and
- Burning.

Generally, there is sufficient clinical evidence if any of the following has been identified:

1. One Class A finding; or
2. Two of the Class B findings; or
3. One Class B and two Class C findings.

Cases in which this criterion is not satisfied may require additional justification.

The Mississippi Medicaid program limits benefits for routine foot care required as a result of or associated with systemic conditions to once every 60 days. The provider must not submit claims for services above and beyond this limit. It is the responsibility of the provider to monitor the frequency for submitting the claims for services.

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The provider must not routinely file for visit codes with the routine foot care procedures. If the provider provides additional treatment that justifies use of a visit, the provider may bill the appropriate level of service. If the provider bills a routine foot care code with a visit, the provider is responsible for maintaining appropriate documentation in the medical record that justifies the charges for a visit. The provider must be aware of the limitations of Medicaid benefits for visits and should work with the beneficiaries in utilizing their visits wisely.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.10</b>	
	<b>Pages: 1</b>	
<b>Subject: Supplies/Surgical Trays</b>	<b>Cross Reference:</b>	
	<b>Supplies/Surgical Trays 52.16</b>	

Refer to Surgery, Section 52.16, in the Provider Policy manual.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.12	
	<b>Pages:</b> 1	
<b>Subject: Supportive Devices/Shoes</b>	<b>Cross Reference:</b>	

Orthopedic shoes, any other type shoe, and/or other supportive devices for the feet are not covered.

This includes, but is not limited to, custom molded shoes, metatarsal bars, arch supports, shoe inserts and braces.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.13</b>	
	<b>Pages: 2</b>	
<b>Subject: Surgery Guidelines</b>	<b>Cross Reference: Multiple Surgery 52.03</b>	

Refer to Surgery, Section 52.0 in this manual.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.14</b>	
	<b>Pages: 1</b>	
<b>Subject: Avulsions/Excision of Nail/Nail Matrix for Ingrown Toenails and Other Conditions</b>	<b>Cross Reference:</b>	

**Avulsion/Excision of Nail/Nail Matrix for Ingrown Toenails**

The big toe is the most commonly affected toenail and the 5<sup>th</sup> or the little toe hardly ever develops ingrown toenails. Others may be affected but the condition is not common. Ingrown toenails can be associated with, and may actually cause, Daronvchia of the toenails.

Recommended treatments may vary from trimming of the toenail, partial or complete avulsion or wedge excision of the skin of the nail fold, to excision of nail and nail matrix, partial or complete for permanent removal.

The following codes apply to surgical treatment of ingrown toenails:

- 11730 Avulsion of nail plate, partial or complete, simple; single
- 11732 Each additional nail plate (List separately in addition to code for primary procedure)

An avulsion can consist of total nail plate removal or merely removing the ingrown strip of nail. The nail bed and matrix are not involved. A new nail will grow back.

Before treatment of an ingrown or embedded toenail (onychocryptosis) can be approved by Medicaid, localized pathology of the soft tissue surrounding the nail must demonstrate that it is severe enough to require professional intervention. Documentation in the records of the use of a local anesthetic is required for codes 11730 and 11732 such as local infiltration or nerve blocks with Lidocaine, Marcaine, etc. This documentation should include the name of the medicine, route of administration, and dosage.

Avulsing small chips after trimming of the thickened/elongated nails that may have been painful under the diagnosis of ingrown toenail is considered equivalent to routine foot care and is not covered under Medicaid.

- 11750 Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;

CPT 11750 represents all excisions of all borders carried out on a nail. The provider must report a single 11750 and must not report a separate 11750 for each border. Partial/total matrixectomies can be performed either with surgical or chemocautery techniques with anesthesia.

**Avulsion/Excision of Nail/Nail Matrix for Other Conditions**

For other conditions of the nails, such as trauma or conditions other than ingrown toenails, requiring avulsion or excision of the nails, apply the same guidelines indicated above for 11730, 11732 and 11750.

<b>Division of Medicaid</b>	<b>New:</b>	<b>X</b>	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>		<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>		
<b>Section: Foot Care</b>	<b>Section:</b>	<b>42.15</b>	
	<b>Pages:</b>	<b>1</b>	
<b>Subject: Debridement</b>	<b>Cross Reference:</b>		

CPT codes 11000 through 11044 are considered to be part of the essential treatment of the surgery codes and are not separate procedures, unless gross contamination requires prolonged cleansing.

For ulcers, the provider must document in the medical record the size, appearance, location, and any treatments or procedures on the foot.

Ulcer care is limited to ten (10) days of care after which a treatment plan must be submitted with the claim. It is important that the type of treatment be specifically identified. The treatment plan should include information such as the cause and stage of the ulcer, location and size, specific treatment, frequency of treatment, expected results, etc.



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.17</b>	
	<b>Pages: 2</b>	
<b>Subject: Fungal Disease of the Toenails-Onychomycosis</b>	<b>Cross Reference:</b>	

Fungal disease of the toenails is a comparatively benign condition but difficult to eradicate due to the high recurrence rate. The only definitive treatment is a prolonged course of oral antifungal drugs or initial debridement followed by a meticulous program of self-care by the patient with topical exfoliates and antifungal drugs.

Surgical debridement of mycotic nails with a manual or electric grinder method is considered routine foot care and not covered unless both of the following conditions exist:

1. There must be clinical evidence of mycosis of the toenail contained in the physician's medical record.

**AND**

2. The medical records must document the severity of the condition and there must be compelling medical evidence documenting either:
  - A. Ambulatory patient: The patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate;

**OR**

- B. Non-ambulatory patient: The patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

If both of the conditions are met, the provider may file for surgical debridement of mycotic nails.

Surgical debridement of nails must be reported under the following codes:

11720 Debridement of nail(s) by any method(s); one to five

11721 Six or more

Medical necessity must be documented by the use of the proper ICD-9 code on the CMS-1500 claim form.

Mycotic nails submitted without additional substantiating medical evidence will result in the service being denied as routine foot care. The provider must also document the complicating condition of the nail which limits ambulation.

The Mississippi Medicaid program limits benefits for debridement of mycotic nails to once every 60 days. The provider must not submit claims for services above and beyond this limit. It is the responsibility of the provider to monitor the frequency for submitting claims for this service.

The provider must not routinely file for visits with the debridement of nails CPT codes 11720 and/or 11721. If the provider provides additional treatment that justifies use of a visit, the provider may bill the appropriate level of service. If the provider bills for the debridement of nail code with a visit, the provider is responsible for maintaining appropriate documentation in the medical record that justifies the charge for a visit.

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The provider must be aware of the limitations of Medicaid benefits for visits and should work with the beneficiary in utilizing their visits wisely.

The provider may not bill a routine foot care code with the debridement of nails code for the same nail on the same date of service. Routine foot care may not be substituted for debridement of nails codes when the once every 60 day limit has been utilized.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.18	
	<b>Pages:</b> 1	
<b>Subject: Hammertoe</b>	<b>Cross Reference:</b>	

The Mississippi Medicaid allowance for hammertoe surgery (CPT 28285) includes all procedures necessary to correct the toe.

28285 Correction, hammertoe (e.g., interphalangeal fusion, partial or total phangectomy)

Procedures such as CPT 28153 or 28160 should not be billed in conjunction with hammertoe surgery performed on the same date of service.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.19	
	<b>Pages:</b> 1	
<b>Subject: Paronychia</b>	<b>Cross Reference:</b>	

In the case of toes, paronychia is associated with deformed toenails or ingrown toenails, combined with poorly fitted shoes. The first toenail is the most commonly affected member. Depending upon the duration for which the causative problem has been present, the paronychia may result in:

- Stage A: Inflammation and pain only
- Stage B: Infection, pain and abscess formation

During the stage of inflammation, most of the authorities agree that a mere change of shoes and/or cutting/debridement of the offending nail or inserting lamb's wool between the nail fold and the affected nail are the treatments of choice. When infection has set in, the common treatment is partial avulsion of the offending toenail, or excision of the ingrown wing with removal of the pus.

If evaluation and advice for proper care of feet (e.g., placement of lamb's wool, suggestions for changing shoes, etc.) is the only service rendered for management of Stage A of paronychia, the appropriate E & M code should be claimed.

For management of Stage B of paronychia in which incision and drainage (I&D) is performed, use CPT codes 10060 and 10061.

- 10060 Incision and drainage of abscess (eg, carbuncle suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- 10061 Complicated or multiple

If partial or complete avulsion was required, use CPT codes 11730 through 11732.

For the surgical treatment of paronychia, the provider may use either the I & D code or the avulsion codes. Both procedures cannot be claimed on the same nail.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.20	
	<b>Pages:</b> 1	
<b>Subject: Subluxation of the Foot</b>	<b>Cross Reference:</b>	

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

This exclusion does not apply to medical or surgical treatment of subluxation of the ankle joint (talo-crural joint). In addition, reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures, is covered. For example, if a patient has osteoarthritis, coverage is provided.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.21	
	<b>Pages:</b> 1	
<b>Subject: Viral/Plantar Warts</b>	<b>Cross Reference:</b>	

Definitive treatment of viral or plantar warts is not considered routine foot care. As a result, services provided for the definitive treatment of viral or plantar warts on the foot are covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Definitive treatment of viral or plantar warts may be identified by the following CPT code examples:

1. Destruction with cautery and curettement (e.g., CPT codes 11055, 11056, and 11057 or 17000, 17003, and 17004 or 11200 and 11201)
2. Excision of Lesion (e.g., CPT codes 11420 - 11426)

The specific ICD-9 code for viral warts is 078.10 and for plantar warts 078.19. Providers must not label other conditions like calluses, etc. under this diagnosis code.

If warts are removed by cautery, the medical records should show the number of lesions removed, their location and size, and the type of cautery used, i.e., chemical or electric.

If warts are removed by surgical excision, a brief operative note and pathology report on the excised tissue should include the number of specimens, their location and size, and any/all microscopic findings should be included in the medical record.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.22</b>	
	<b>Pages: 1</b>	
<b>Subject: Non-Invasive Vascular Testing by Doctors of Podiatric Medicine</b>	<b>Cross Reference:</b>	

There are variations in the scope of podiatry practice from state-to-state. The Mississippi law states:

"Diseases and conditions of the feet produced by kidney, heart and other systemic diseases are not to be treated by persons under this Chapter, except under the direction and supervision of a regularly licensed physician of this State."

Peripheral vascular disease is a systemic condition. The Doppler (other than hand held Doppler which is excluded from coverage) is considered a non-invasive vascular diagnostic test pertaining to a systemic disease and, therefore, out of the scope of the podiatry practice.

Patients with a potential surgical problem of the foot with a question of vascular compromise recognized by the podiatrist, should have at the same time the benefit of medical care by a physician trained to diagnose and manage peripheral vascular disease.

<b>Division of Medicaid</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.23	
	<b>Pages:</b> 1	
<b>Subject: Surgical and Medical Visits</b>	<b>Cross Reference:</b>	

Mississippi Medicaid policy does not allow the separate reimbursement of most Evaluation and Management (E&M) services when a substantial diagnostic or therapeutic procedure is also performed. Medical visit auditing is handled through the McKesson ClaimCheck software.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> X	<b>Date:</b> 03/01/07
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section:</b> 42.24	
	<b>Pages:</b> 2	
<b>Subject: Exclusions Relating to Foot Care</b>	<b>Cross Reference:</b>	

The following is a list of some of the exclusions under the Mississippi Medicaid program which relate to foot care. While these are the most common exclusions, this is not intended to be a comprehensive list.

- Local anesthesia, digital blocks, or topical anesthesia done with a specific surgical procedure (included in allowance for procedure)
- Orthopedic shoes and supportive devices for the foot
- Cast application/strapping/splinting billed separately from initial surgery or fracture care on same day as initial surgery or fracture care (initial cast application/strapping/splinting is covered in allowance for initial surgery or fracture care)
- Removal of casts/straps/splints (covered in allowance for original procedure)
- Laboratory services done or ordered by DPM relating to care of systemic conditions
- Fungal cultures on toenail clippings
- Ultrasound for patients with diagnosis of diabetes
- Foot massage
- Whirlpool for mycotic nail treatment
- Routine foot care in the absence of systemic conditions
- Surgical trays except for certain approved procedures
- Supplies
- Biopsies performed in conjunction with a surgical procedure
- Services for treatment of "flat foot"
- Surgical or non-surgical treatment undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity
- Non-invasive vascular testing by Doctors of Podiatric Medicine
- Expanded EPSDT services for children under twenty one (21) years of age for which prior authorization has not been obtained from the Division of Medicaid
- Services performed for conditions "above the ankle" unless within the scope of the provider's licensure
- Services performed outside of the scope of licensure for the specific physician's specialty
- Services that are not medically necessary for the diagnosis and treatment of the condition of the foot

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- Items or services which are furnished gratuitously without regard to the individual's ability to pay and without expectation of payment from any source, such as free x-rays provided by a health department
  - Cosmetic surgery directed primarily at improvement of appearance and not for correction of defects resulting from trauma, disease, or birth defects
  - Routine physician checkups that are not part of the screening program for beneficiaries under twenty one (21) years of age which include examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury
  - Immunizations or other preventive health services that are not a part of the screening program for beneficiaries under twenty one (21) years of age and are not related to treatment of injury or direct exposure to a disease such as rabies or tetanus
  - Prosthetic devices and orthopedic shoes for beneficiaries twenty one (21) years of age or older, except for crossover claims allowed by Medicare
  - Vitamin injections, except for B-12 as specific therapy for certain anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia; certain gastrointestinal disorders: gastrectomy, malabsorption disorders such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome; certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of the following: multiple sclerosis, trigeminal and glossopharyngeal neuralgia, neuropathies of malnutrition and alcoholism, tabes dorsalis, herpes zoster, and other inflammatory neuritis not due to mechanical or traumatic etiology
  - Interest on late pay claims
  - Physician assistants
  - Reimbursement for QMBs, except for Medicare/Medicaid crossover payments of Medicare deductibles and coinsurance
  - Reimbursement for any Medicaid service for Specified Low-Income Medicare Beneficiaries (SLMBs) group. They are entitled only to payment of their Medicare Part B premium.

<b>Division of Medicaid</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
<b>State of Mississippi</b>	<b>Revised:</b>	<b>Date:</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.25</b>	
	<b>Pages: 1</b>	
<b>Subject: Nerve Block Injections</b>	<b>Cross Reference:</b>	

A nerve block is the injection of a local anesthetic or a neurolytic agent into or near a peripheral nerve, a sympathetic nerve plexus, or a local pain-sensitive trigger point. Nerve blocks may be used intraoperatively to prevent pain of the procedure, diagnostically to ascertain cause of pain, or therapeutically to relieve chronic pain.

Local infiltration, metacarpal/metatarsal/digital blocks, or topical anesthesia are covered in the allowance for specific surgical procedures. The provider must not bill separately for these anesthesia procedures.

For direct injections into joints, etc. do not use CPT code 64450. This code is used only for diagnostic or therapeutic injection into a peripheral nerve.

When a nerve block is billed alone and is for the treatment of a non-surgical condition, such as Morton's neuroma, it should be billed under the appropriate injection/block code.

**Documentation for Nerve Block Injections**

Physician documentation in the patient's medical record must support the reasonableness and medical necessity of the service and must indicate that more conservative therapy has not been effective. The documentation must adequately describe the patient's clinical state (history, physical findings, laboratory and other tests), e.g., identification of the problem including diagnosis, precipitating events, quantity and quality of pain, test results, response to previous therapy, the procedure performed including the area injected, the substance(s) injected and the dosage of the substance (s).

All coverage criteria must be clearly documented in the patient's medical record and made available to the Division of Medicaid, and its authorized agents, upon request.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 03/01/07</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Foot Care</b>	<b>Section: 42.26</b>	
	<b>Pages: 1</b>	
<b>Subject: Consultation Services Rendered by a Podiatrist In a Skilled Nursing Facility</b>	<b>Cross Reference:</b>	

A consultation is distinguished from a visit because it is done at the request of a referring physician. The consultant prepares a report of his/her findings which is provided to the referring physician for use in treatment of the patient.

To determine whether the consultation comes within the foot care exclusions, DOM will apply the same rule as for initial diagnostic examinations, i.e., where services are performed in connection with specific symptoms or complaints which suggest the need for covered services, the services are covered regardless of the resulting diagnosis.

For Mississippi Medicaid, an initial consult visit by a podiatrist to a beneficiary in a skilled nursing facility is limited to one initial visit per beneficiary every three years. Visits following an initial consult, if necessary, should be coded with the appropriate Evaluation and Management CPT codes. It is the responsibility of the provider to be aware of the number of visits a beneficiary is allowed per fiscal year (July 1 through June 30) and to use those visits wisely.

Routine foot examinations by a podiatrist are excluded on all patients in a skilled nursing facility on a routine basis for screening purposes.