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8.310.11 PODIATRY SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 11 PODIATRY SERVICES

8.310.11.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.310.11.1 NMAC - Rp, 8 NMAC 4.MAD.000.1, 7/1/04; A, 1/1/09]

8.310.11.2 SCOPE: The rule applies to the general public.
[8.310.11.2 NMAC - Rp, 8 NMAC 4.MAD.000.2, 7/1/04]

8.310.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, or state statute. See NMSA 1978 Section 27-2-12 et seq.
[8.310.11.3 NMAC - Rp, 8 NMAC 4.MAD.000.3, 7/1/04; A, 1/1/09]

8.310.11.4 DURATION: Permanent
[8.310.11.4 NMAC - Rp, 8 NMAC 4.MAD.000.4, 7/1/04]

8.310.11.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.310.11.5 NMAC - Rp, 8 NMAC 4.MAD.000.5, 7/1/04]

8.310.11.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.310.11.6 NMAC - Rp, 8 NMAC 4.MAD.000.6, 7/1/04; A, 1/1/09]

8.310.11.7 DEFINITIONS: [RESERVED]

8.310.11.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) of HSD is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.310.11.8 NMAC - Rp, 8 NMAC 4.MAD.002, 7/1/04; A, 1/1/09]

8.310.11.9 PODIATRY SERVICES: The New Mexico MAD pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for covered services.
[8.310.11.9 NMAC - Rp, 8 NMAC 4.MAD.718.2, 7/1/04; A, 1/1/09]

8.310.11.10 ELIGIBLE PROVIDERS:

A. Upon approval of a New Mexico medical assistance division provider participation agreement by MAD or its designee, licensed practitioners or facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. Once enrolled, providers receive instruction on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program policy manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement, and all applicable statutes, regulations, and executive orders.

B. The "practice of podiatry" is defined as engaging in that primary health care profession, the members of which examine, diagnose, treat, and prevent by medical, surgical and mechanical means ailments affecting the human foot and ankle and the structures governing their functions, but does not include amputation of the foot or the personal administration of a general anesthetic. See NMSA 1978 Section 61-8-2 (Repl. Pamp. 1991).
[8.310.11.10 NMAC - Rp, 8 NMAC 4.MAD.718.21, 7/1/04; A, 1/1/09]

8.310.11.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS:

A. Providers who furnish services to medicaid eligible recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services as specified in the MAD provider participation agreement. A provider also agrees to conform to MAD program rules and instructions as specified in this manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or up-coding services.

B. **Documentation requirements:** Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to eligible recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(b)]. Documentation supporting medical necessity must be legible and available to MAD or its designee upon request.

(1) For foot care services covered due to the presence of systemic disease, documentation of the clinical condition of the feet should contain sufficient detail to provide evidence that non-professional performance of the service would have been hazardous for the eligible recipient. The eligible recipient's records must include the following:

(a) a clinical description of the feet; simply listing class findings is insufficient;

(b) description of co-morbid conditions such as infections or abscesses; and

(c) documentation of appropriate attempts to alleviate conditions that contribute to foot problems.

(2) To the extent that management of an underlying systemic disease impacts the need for or expected outcome of management of the feet, the status of the systemic disease should be recorded. Documentation is to be repeated in the record as often as necessary to accurately portray the eligible recipient's current condition at the time of billed services.

(3) For eligible recipients whose foot care is covered due to the presence of a systemic condition that requires active treatment, documentation by the treating physician is to include corroboration of the systemic condition diagnosis and active treatment of the systemic disease.

(4) Documentation of foot care services to an eligible recipient in a nursing home must include a current nursing facility order (dated and signed with date of signature) for routine foot care service, issued by the eligible recipient's supervising physician, that describes the specific service necessary. Such orders must meet the following requirements.

(a) The order must be dated and must have been issued by the supervising physician prior to foot care services being rendered.

(b) Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within 30 calendar days following the issuance of the order.

(c) The order must be consistent with the attending physician's plan of care; the order must be for medically necessary services to address a specific eligible recipient's complaint or physical finding.

(d) Routinely issued or "standing" facility orders for routine foot care service and orders for non-specific podiatric services that do not meet the above requirements are insufficient.

(e) Documentation of foot care services to an eligible recipient in a nursing home performed solely at the request of the eligible recipient or their personal representative must include the identity of the person who requested the services and that person's relationship to the eligible recipient.

(5) The eligible recipient's record must include the location of each lesion treated and specific mention (by number or name) and description of each nail treated.

(6) For foot care services for an eligible recipient with diabetic sensory neuropathy and loss of protective sensation (LOPS), the eligible recipient's history should include, but is not limited to, how, when and by whom the diagnosis of LOPS was made, as well as any pertinent present or past history regarding the feet.

(7) The eligible recipient's history should include, at the least, an interval history regarding the feet since the previous evaluation for follow-up physician evaluation and management of an eligible recipient with diabetic sensory neuropathy resulting in a LOPS.

(8) For coverage of mycotic nail debridement by reason of the presence of specified conditions, that is, in the absence of a qualifying systemic condition, the medical record must document the following:

(a) eligible recipient's description of the pain including such things as severity, duration, contextual information, modifying factors, specification regarding which nail(s) is painful, etc.;

(b) description of eligible recipient's functional limitation due to the nail(s);

(c) description of any secondary infections; and

(d) description of other modalities of treatment to which debridement or other surgical procedure is adjunctive (in the event that pharmacologic therapy is contraindicated or otherwise not indicated, the nature of the contraindication should be described).

(9) Debridement must be distinguished from trimming or clipping and records supporting each billed debridement should indicate what portion of the nail was not attached to the nail bed and what portion of the nail was removed.

(10) Services not substantiated in the eligible recipient's records are subject to recoupment. See 8.351.2 NMAC, *Sanctions and Remedies*.

[8.310.11.11 NMAC - Rp, 8 NMAC 4.MAD.718.22, 7/1/04; A, 1/1/09]

8.310.11.12 COVERED SERVICES: MAD covers only medically necessary podiatric services furnished by providers, as required by the condition of the eligible recipient. All services must be furnished within the scope and practice of the podiatrist as defined by state law, the New Mexico board of podiatry licensing requirements, and in accordance with applicable federal, state, and local laws and regulations. MAD covers the following specific podiatry services.

A. Routine foot care when there is evidence of a systemic condition, circulatory distress or areas of diminished sensation in the feet demonstrated through physical or clinical determination and if the severity meets the class findings (as in Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC). An eligible recipient with diagnoses marked by an asterisk(*) in the list below must be under the active care of an M.D. or D.O. to qualify for covered routine foot care, and must have been assessed by that provider for the specified condition within six months prior to or 60 calendar days after the routine foot care service. Nurse practitioners, physician assistants and clinical nurse specialists do not satisfy the coverage condition of "active care by a physician".

(1) The following list of systemic diseases is not all-inclusive and represents the most commonly billed diagnoses which qualify for medically necessary foot care:

(a) diabetes mellitus*;
(b) arteriosclerosis obliterans;
(c) buerger's disease;
(d) chronic thrombophlebitis*;
(e) neuropathies involving the feet associated with:
(i) malnutrition and vitamin deficiency*;
(ii) malnutrition (general, pellagra);
(iii) alcoholism;
(iv) malabsorption (celiac disease, tropical sprue);
(v) pernicious anemia;
(vi) carcinoma*;
(vii) diabetes mellitus*;
(viii) drugs or toxins*;
(ix) multiple sclerosis*;
(x) uremia (chronic renal disease)*;
(xi) traumatic injury;
(xii) leprosy or neurosyphilis;
(xiii) hereditary disorders;
(xiv) hereditary sensory radicular neuropathy;
(x) fabry's disease; and
(xvi) amyloid neuropathy.

(2) Routine foot care services can be covered for an eligible recipient who has a systemic condition that can be covered (as in Subparagraphs (a) through (e) of Paragraph (1) of Subsection A of 8.310.11.12 NMAC) and if the severity meets the class findings as follows: one of class A findings; or two of class B findings; or one of the class B findings and two of the following class C findings:

(a) **Class A findings:** non-traumatic amputation of foot or integral skeletal portion thereof.
(b) **Class B findings:**
(i) absent posterior tibial pulse;
(ii) absent dorsalis pedis pulse; and

(iii) advanced trophic changes as evidenced by any three of the following: hair growth (decrease or increase); nail changes (thickening); pigmentary changes (discoloring); skin texture (thin, shiny); or skin color (rubor or redness).

(c) **Class C findings:**

(i) claudication;

(ii) temperature changes (e.g., cold feet);

(iii) edema;

(iv) paresthesias (abnormal spontaneous sensations in the feet); or

(v) burning.

B. Non-surgical and surgical correction of a subluxated foot structure that is an integral part of the treatment of foot pathology or that is undertaken to improve the function of the foot or to alleviate an associated symptomatic condition, including treatment of bunions, is covered when medical necessity has been documented. Treatment for bunions is limited to capsular or bony surgery. The treatment of subluxation of the foot is defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles in the foot.

C. Treatment of warts on the feet.

D. Treatment of asymptomatic mycotic nails may be covered in the presence of a systemic condition that meets the clinical findings and class findings as required for routine foot care. See Subparagraphs (a) through (c) of Paragraph (2) of Subsection A of 8.310.11.12 NMAC.

E. Treatment of mycotic nails is covered in the absence of a covered systemic condition if there is clinical evidence of mycosis of the toenail and one or more of the following conditions exist and results from the thickening and dystrophy of the infected nail plate:

(1) marked, significant limitation;

(2) pain; or

(3) secondary infection.

F. Orthopedic shoes and other supportive devices only when the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.

G. If the eligible recipient has existing medical condition(s) that would predispose the eligible recipient to complications even with minor procedures, hospitalization for the performance of certain outpatient podiatric services may be covered. All claims related to hospitalization for podiatric procedures are subject to pre-payment or post-payment review.

[8.310.11.12 NMAC - Rp, 8 NMAC 4.MAD.718.23, 7/1/04; A, 1/1/09]

8.310.11.13 INJECTABLE DRUG SERVICES: MAD covers injectable medications administered by physicians or other healthcare providers furnishing services to an eligible recipient within their scope of practice.

[8.310.11.13 NMAC - N, 7/1/04; A, 1/1/09]

8.310.11.14 LABORATORY AND DIAGNOSTIC IMAGING SERVICES: MAD covers medically necessary laboratory and diagnostic imaging services ordered by practitioners and when furnished by eligible providers to an eligible recipient. See 42 CFR Section 440.30.

A. **Laboratory services:** Podiatrists can bill for medically necessary laboratory services ordered by podiatrists which are either performed by podiatrists or under their supervision. See 8.324.2 NMAC, *Laboratory Services*.

(1) Professional components associated with clinical laboratory services are payable only when the work is actually performed by pathologists who are not billing for global procedures and the work is for anatomic and surgical pathology only, including cytopathology, histopathology and bone marrow biopsies.

(2) Specimen collection fees are payable when obtained by venipuncture, arterial stick, or urethral catherization, unless eligible recipients are inpatients of nursing facilities or hospitals.

B. **Diagnostic imaging services:** Podiatrists can bill for medically necessary diagnostic imaging or radiology services which are either performed by podiatrists or under their supervision. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services* [MAD-752].

(1) The complete procedure includes the technical radiology component and the professional component.

(2) MAD covers one professional component per imaging procedure.

(3) Reimbursement for imaging procedures includes all materials and minor services necessary to perform the procedure. MAD does not pay for kits, films, or supplies, as separate charges.

[8.310.11.14 NMAC - Rp, 8 NMAC 4.MAD.718.26, 7/1/04; A, 1/1/09]

8.310.11.15 NONCOVERED SERVICES: Podiatric services are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. MAD does not cover the following specific services or procedures.

A. Routine foot care is not covered except as indicated under "covered services" for an eligible recipient with systemic conditions meeting specified class findings. Routine foot care is defined as:

(1) trimming, cutting, clipping and debriding toenails;

(2) cutting or removal of corns, calluses, or hyperkeratosis;

(3) other hygienic and preventative maintenance care such as cleaning and soaking of the feet, application of topical medications, and the use of skin creams to maintain skin tone in either ambulatory or bedfast patients; and

(4) any other service performed in the absence of localized illness, injury or symptoms involving the foot.

B. Services directed toward the care or correction of a flat foot condition. "Flat foot" is defined as a condition in which one or more arches of the foot have flattened out.

C. Orthopedic shoes and other supportive devices for the feet are generally not covered. This exclusion does not apply if the shoe is an integral part of a leg brace or therapeutic shoes furnished to diabetics.

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

E. MAD will not reimburse for services that have been denied by medicare for coverage limitations.

[8.310.11.15 NMAC - Rp, 8 NMAC 4.MAD.718.27, 7/1/04; A, 1/1/09]

8.310.11.16 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, before payment is made or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, the provider receives instructions on how to access provider program rules, billing instructions, utilization review instructions, and other pertinent material and to obtain answers to questions on or not covered by these materials. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements.

A. Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.310.11.16 NMAC - Rp, 8 NMAC 4.MAD.718.28, 7/1/04; A, 1/1/09]

8.310.11.17 REIMBURSEMENT:

A. Podiatrists must submit claims for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

B. Reimbursement to providers is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

(a) The provider's billed charge must be the provider's usual and customary charge for services.

(b) "Usual and customary charge" refers to the amount that the individual provider charges the general public in the majority of cases for a specific procedure or service.

[8.310.11.17 NMAC - Rp, 8 NMAC 4.MAD.718.29, 7/1/04; A, 1/1/09]

HISTORY OF 8.310.11 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: ISD 310.1100, Podiatry Services, filed 2/13/80.

ISD 310.1100, Podiatry Services, filed 10/14/81.
ISD Rule 310.1100, Podiatry Services, filed 2/28/83.
ISD Rule 310.1100, Podiatry Services, filed 2/21/86.
MAD Rule 310.11, Podiatry Services, filed 12/15/87.
MAD Rule 310.11, Podiatry Services, filed 4/27/88.
MAD Rule 310.11, Podiatry Services, filed 4/20/92.

History of Repealed Material:
MAD Rule 310.11, Podiatry Services, filed 4/20/92 - Repealed effective 2/1/95.
8 NMAC 4.MAD.718.2, Podiatry Services, filed 1/18/95 - Repealed effective 7/1/04.

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5/22/04
Art sent me this version. Rebecca Lopez & I typed in Virginia's changes per final register on Podiatry Services.
History note 7/1/04.
This is a repeal (MAD-718.2) and replace (8.310.11) since she made so many changes.
No part version will be needed.

6/4/04 this has Susan's changes.
6/8/04 this has Robert and more of Susan's changes.

6/29/04
This is Arts integrated version after the 7/1/04 filing.

10/1/07 Emailed to Jennifer Tollefson-Chavez per her request
5/12/08 hearing
10/6/08 OGC changes made; eff date 11/1/08 changed to 1-1-09

10/05/2012 Sent to Mercer