~~CHAPTER IV~~

~~COVERED SERVICES AND LIMITATIONS~~

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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

OVERVIEW

This chapter describes the coverage available to Department of Medical Assistance Services (DMAS) recipients for podiatry services. A description of covered and non-covered podiatry services, as well as the limitations that have been imposed on covered services, is included.

COVERED SERVICES

Covered podiatry services are defined as reasonable and necessary diagnostic, medical, surgical (mechanical, physical, and adjunctive) treatment of disease, injury, or defects of the human foot. Amputation of the foot or toes is not covered. The trimming of toenails is covered only if the patient has a systemic condition that has results in severe circulating embarrassment or areas of desensitization in the legs or feet. No other trimming of toenails is covered; see the section on page 10 entitled "NON-COVERED SERVICES AND LIMITATIONS."

DMAS requires the use of codes and definitions published in Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) in billing covered services. The CPT-4 manual may be obtained from:

Order Department (OP-341/6)
American Medical Association
P. O. Box 10946
Chicago, Illinois 60610-0946

Specify order number OP-341/6.

~~Podiatry coverage is further limited to the CPT-4 procedures listed in Appendix C of this manual.~~

~~The diagnosis and treatment of disorders to facilitate ambulation and promote progress to a lower level of care, including self-care, will be covered by DMAS. Services provided must be within the scope of the license of the podiatrist's profession as defined by State law and must be in accordance with the ethical and professional standards of the podiatry profession.~~

~~Services provided free to the general public cannot be billed to DMAS. This exclusion does not apply when items and services are furnished to indigent individuals without charge because of the individual's inability to pay, as long as the provider bills other patients for the same services according to their ability to pay.~~

~~Medicaid can only pay for services performed by the attending participating podiatrist or under his direct, personal supervision. For purposes of this program, direct personal supervision means immediately available, or physically present when the procedure is being performed, and assuming full responsibility. Records must fully disclose a sufficient amount of information to indicate the extent and nature of the podiatrist's participation in the care and treatment of the patient.~~

~~Laboratory and X-Ray Procedures~~

~~Payment for laboratory and X-ray services will be made directly to the provider performing the service (i.e., physician, independent laboratory, or other participating facility). The ordering podiatrist may bill for collection of specimens sent to the laboratory when billed as a single unit under Current Procedural Terminology (CPT) Code 99000. Only one collection fee is allowed per office visit. Laboratory procedures performed by outside sources at no charge to the practitioner are not to be billed to Medicaid and only a collection fee will be paid.~~

~~Whenever laboratory tests are performed that are generally part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing:~~

- ~~The CPT delineates tests that are frequently done as part of a chemistry profile. When **two** or more of these lab tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. CPT Codes 80000-80019 are to be used, and the code used must correlate with the number of tests performed. Only one panel code is to be used per specimen. If only one procedure is performed, use the appropriate CPT procedure code which describes the individual test.~~

- ~~Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT code is to be used (85021-85031). CPT Codes 85021-85028) are to be used when specimens are tested using automated~~

equipment, and CPT Code 85031 is to be used when specimens are tested manually.

- If fewer than four components of a hemogram are performed, they are to be billed using the appropriate individual CPT Codes.

- "Routine" foot X-rays are included in the initial evaluation. Payment for additional X-rays will be made only if additional X-rays are deemed medically necessary by DMAS. Evidence to substantiate additional X-rays must be included in the "Remarks" section of the invoice (e.g., postoperative, healing fracture, etc.).

- Comparative X-rays of the asymptomatic foot are covered only when the cause of the disorder is uncertain.

Non-Covered Services

The following laboratory and X-ray services are specifically **EXCLUDED** from coverage and payment:

- Services performed on a routine basis but not medically indicated by the patient's symptoms.

- Laboratory test professional component (Modifier A) for procedures performed in the office, outpatient hospital, or in the independent laboratory. Payment for **supervision** and **interpretation** is included in the full procedure payment.

- Sensitivity studies when a culture shows no growth. Payment will only be made for the culture.

- X-ray procedure professional component (Modifier A) for procedures performed by an independent laboratory (portable X-ray service) or another physician performing a complete procedure. "Modifier E" is to be used by the physician billing only for the use of radiology equipment (technical component). The technical component can only be billed in conjunction with another physician billing **only** for professional components.

Hospital Visits

Payment to podiatrists for hospital visits is limited to the approved number of days of the inpatient hospital stay. Inpatient hospital care is provided for days that are medically necessary and are limited to a maximum of 21 days. This 21-day limit applies to 21 days of hospitalization for the same diagnosis within a 60-day period. The 60-day period begins with the first approved day of a hospital admission. Only 21 total days will be covered for the same diagnosis, whether incurred in one or more hospital stays or in the same or multiple hospitals, during the 60-day period. Claims for more than 21 days will be reviewed for possible coverage. In order for hospital days over 21 to be covered, the visits must be for a different diagnosis and medically justified.

Exception to 21-Day Limit on Inpatient Hospital Stays
[Effective Date: October 1, 1986]

The Medicaid Program will pay for all medically necessary inpatient hospital stays and related provider services for recipients younger than 21 years of age. This extended coverage is allowed through the EPSDT Program. The revised policy for inpatient care in acute care hospitals is as follows:

- Patients, 21 years or older are limited to 21 days of covered hospitalization within 60 days for the same or similar diagnosis.
- Patients under 21 years of are not affected by the limitation on covered hospital services. The program covers their entire length of medically necessary hospitalization until their 21st birthday.
- Patients who become 21 years of age while hospitalized for medically necessary stays are entitled to an additional 21 days for the same or similar diagnosis from the date of their 21st birthday.

Hospital coverage for preoperative work-up will be limited to one day prior to non-emergency surgery.

Non-emergency admissions on Friday and Saturday will not be covered.

Hospital visits are not payable in conjunction with diagnostic procedures.

House Calls

Payment for house calls is limited to patients who are bedridden and for whom a trip to a podiatrist's office would be detrimental to both safety and health.

Pharmacy Services

To ensure that payment can be made for the prescribed drug(s), each prescriber must include his DMAS provider number on the prescription. This number is also necessary for prescriptions made by telephone. The billing pharmacy must identify the prescriber by including the prescriber's DMAS provider number on the invoice before payment can be approved.

All recipients, except those exempted, are required to pay the dispensing pharmacy a $1.00 copayment on each prescription qualifying for a copayment.

Maintenance drugs must normally be prescribed in quantities reflecting at least a 30-day supply or 100 units or doses, except when otherwise indicated by the patient's medical/psychological condition (effective January 15, 1975). Transdermal delivery systems (patches), anorexiants except those for selected patients meeting disability

standards for obesity established by the Social Security Administration and whose condition is life-threatening (effective July 1, 1997), and drugs identified by the Federal Food and Drug Administration (FDA) as lacking substantial evidence of effectiveness in the Drug Efficacy Study Implementation (DESI) Program are not covered by Virginia Medicaid.

Diabetic test strips for recipients under 21 years of age are covered (effective July 1, 1989).

Anorectic drugs, including, but not limited to, Preludin, Dexedrine, Dexamyl, etc, are not covered by DMAS.

Early Refill Denial Edit and Therapeutic (Class) Duplication Edit

DMAS has an early refill denial edit and therapeutic (class) duplication edit as an enhancement of the Medicaid ProDUR activities requirement. These Point-of-Service (POS) edits expand ProDUR activities to include the denial of unjustified requests for early prescription refills or therapeutic (class) duplicate products. In the unusual situations identified below, a mechanism has been provided for override of the denial.

"Early refill" is defined as "when a prescription refill is requested before 75% of the calculated days' supply has elapsed for the previously filled prescription." Providers must take extra care in verifying that a correct amount is shown for the "days' supply" entry for all prescriptions.

Additionally, a denial edit for therapeutic duplication will occur when a product in the same therapeutic drug class as a concurrently utilized product (e.g., concurrent use of two calcium channel blockers) is billed. The following groups of drugs will be subject to therapeutic duplication alerts:

- ACE Inhibitors;
- Antidepressants;
- Anti-Ulcer;
- Benzodiazepines;
- Calcium Channel Blockers;
- Cardiac Glycosides;
- Diuretics; and
- Non-Steroidal Anti-Inflammatory Drugs (NSAIDs).

A payment denial code will require the provider to reverse the claim except in those cases where a valid reason can be documented for the need to override the denial.

In the following unusual circumstances, the pharmacist may override the denial

A. Only the following reasons may be used as justification for override of early refill edits:
   1. **"Temporary Exemption"** - Need determined by travel distance, transportation availability, or travel out of area;
   2. **"Missing Medication"** - Waste, spilled, lost, stolen, destroyed, or damaged drug supply;
   3. **"Data Entry Error (days' supply)"** - Keying error or underestimation of use pattern; and
   4. **"Clinical Justification"** - Dose increase authorized by the prescriber, etc.

B. Only the following reasons may be used as justification for override of the therapeutic duplication edit:

   1. **"Original Drug Discontinued. New Drug Ordered."** - Discontinued use of one drug and subsequent new prescription issued in the same therapeutic drug class (e.g., substitution of one calcium channel blocker for another); and
   2. **"Physician Contacted, Deems Duplicate Therapy Necessary."** - Pharmacist's professional judgment still must be used to ensure the patient will not be at risk from such duplication.

Pharmacy Coverage for Outpatients Including Payment for Certain Over-the-Counter (OTC) Products When Used as Therapeutic Alternatives to More Costly Legend Drugs and Payment Methodology for OTC Products and Oral Contraceptives

Previous coverage of pharmaceuticals for Virginia Medicaid recipients in the outpatient setting allowed coverage of OTC family planning drugs and supplies, as well as insulin, syringes, and needles. After extensive expert panel review and public comment, the Board of Medical Assistance Services (BMAS) determined that certain categories of over-the-counter (OTC) products also may be used appropriately as less costly therapeutic alternatives to certain categories of prescription only (legend) drugs.

The purpose of this initiative is to allow the use of cost-saving alternatives in the prescription program, not to allow general coverage of all OTC products. Therefore, these products should only be prescribed for outpatients *when the provider otherwise would have used a more expensive legend product*. Note that it is possible to titrate the dose of many of these agents. In this manner, health professionals may choose to adjust the dose or product to suit the individual needs of the patient.

The choice of whether or not to use these additional products will be determined by the patient's prescribing health care provider. This expansion of OTC coverage in the outpatient population will not affect the current coverage standards for categories of drugs included for OTC coverage in the nursing facility environment.

Effective for dates of service on and after February 1, 1997, additional OTC categories of products available for selected outpatients are:

Analgesics, oral

Hematinics

Antacids
Antidiarrheals
Antifungals, topical
Antihistamines
Anti-infective agents, vaginal
Anti-inflammatory agents, oral
Anti-ulcer Preparations
Hydrocortisone, topical
Laxatives, Bulk Producers, Stool Softeners
Pediculocides/Scabicides
Vitamins, pediatric (in established deficiencies)
Vitamins, prenatal
Vitamins or Minerals for dialysis patients

Requests for OTC products will be handled in the same manner as prescriptions. The order may be written as a prescription or transmitted to the pharmacy by any other means which complies with the regulations of the Board of Pharmacy. Documentation is handled in the same manner as prescription drug orders. If the order is not received as a written document, the information must be reduced to writing and filed sequentially, as with any legend drug order. All requirements for storage and retrieval of documents must be observed. The product must be labeled according to the prescriber's order and appropriate counseling must be offered to the patient.

DMAS must rely on the expert professional judgment of its providers to use this cost-saving opportunity to the best advantage. The OTC products will be handled in the same manner as legend drug orders, with no additional documentation required. An analysis of utilization by category of product and provider will be undertaken. Evidence of inappropriate OTC use could stimulate the use of additional program constraints.

Products covered under this program must be supplied by companies participating in the HCFA Medicaid rebate program.

New Drug Coverage
[Effective Date: February 1, 1990]

- Coverage will be denied for new drugs (except treatment investigational new drugs) with available less expensive therapeutic alternatives unless a practitioner obtains prior approval.
- Upon the receipt of an application for the consideration of coverage of a new drug, the New Drug Review Committee will review all new drug products, including the dosage form and selected new strength (e.g., strengths which would result in a change in the dosage regimen or indication for use).

Instructions for Requesting the Preauthorization of and the Billing for a Non-Covered New Drug Product

- The practitioner must complete the Preauthorization Request for Non-Covered New Drug form, DMAS-408 (see "EXHIBITS" at the end of this chapter for a sample of the form), for the original prescription for a non-covered new drug product and maintain a copy of the form in the patient's record.

- The original request form and the prescription must be given to the patient to take to a participating pharmacy of his/her choice. If the prescription is phoned in by the practitioner, a signed and dated preauthorization request form must be mailed immediately to the pharmacy provider chosen by the patient to fill the prescription. (If the patient is in the Client Medical Management Program, he/she must receive services from the assigned provider(s).)

- If the form is properly completed, the pharmacy provider may fill the prescription for the new drug product and submit a claim to the Virginia Medicaid Program for reimbursement. The original Preauthorization Request for Non-Covered New Drug must be attached to the first claim for reimbursement to be made.

- The pharmacy provider having the completed request on file with Virginia Medicaid may continue to dispense and receive reimbursement for prescriptions for a preauthorized non-covered new drug within limitations.

- The practitioner must provide either a new original or copy of an updated preauthorization request form with a current signature to a patient who changes pharmacy providers. The new pharmacy provider will need this preauthorization request form for initial billing purposes.

Multiple Source Drugs - Payment Basis

Under the authority of 1902 (a) (30) (A) and the regulations in 42 CFR 447.332, the Health Care Financing Administration (HCFA) establishes a specific upper limit for certain multiple source drugs if the following requirements are met:

- All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications). See Appendix E for a listing of these drugs.

- At least three suppliers list the drug, which has been classified by the FDA as category "A" in its publication Approved Drug Products With Therapeutic Equivalence Evaluations (including supplements or in successor publications); in the current editions (or updates) of published compendia of cost information for drugs available for sale nationally (e.g., Red Book, Blue Book, Medi-Span).

The upper limit for multiple source drugs for which a specific limit has been established does not apply if a physician **certifies in his or her handwriting that a specific brand is "medically necessary"** for a particular recipient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A checkoff box on a form is not acceptable. The "brand necessary" documentation requirement applies to telephoned prescriptions. **This certification authorizes the pharmacist to fill the**

prescription with the requested brand name product and not to dispense the generic product listed in the Virginia Voluntary Formulary.

In addition, the State Department of Medical Assistance Services has established a Virginia Maximum Allowable Cost for some multiple source drugs listed in the Virginia Voluntary Formulary which are not designated as federal maximum allowable drugs. Again, unless the physician follows the procedures outlined above for specifying a brand necessary drug, the Virginia Maximum Allowable Cost per unit will be used to determine the allowable payment.

Drug Utilization Review Program

State and federal legislation created the directive for the Virginia Medicaid Drug Utilization Review (DUR) program. The purpose of the OBRA 90 DUR Program is to ensure that prescriptions for outpatient drugs are appropriate, are medically necessary, and are not likely to cause adverse results. OBRA 90 further requires that the DUR Program be designed to educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate, or medically unnecessary care. DMAS has established a DUR Board to review and approve drug use criteria and standards for both retrospective and prospective DURs; apply these criteria and standards in the performance of DUR activities; review and report the results of DURs; and recommend and evaluate educational intervention programs. The DUR Board has selected DUR criteria that are representative of clinically important issues. The focus of these criteria is on high risk, high volume, and high cost drugs.

Under the OBRA 90 federal mandate, retrospective DUR is required for outpatients. However, because of a State legislative mandate for nursing facility retrospective DUR, nursing facility patients are also included in the retrospective component of the DUR Program. The criteria used for the nursing facility population is tailored to the needs of the elderly; the data for the outpatient and nursing facility populations will be analyzed and reported separately.

Prospective DUR (prospective review, patient counseling, and patient profiling) is required only for outpatients. Patient counseling is not required for inpatients of a hospital or institution where a nurse or other caregiver authorized by the Commonwealth is administering the medication.

The impact of the DUR Program on Medicaid providers varies. The retrospective component is primarily focused on prescribing patterns and is likely to have more of an effect on physicians and other prescribing providers. The pharmacist is responsible for performing the activities required for the prospective component. As a result, pharmacy providers will be affected by prospective DUR to a greater degree than prescribing providers.

Practitioner's Role in Transportation Services

Transportation for eligible Medicaid recipients is reimbursed by Medicaid when the transportation is necessary for the recipient to receive covered medical services.

NON-COVERED SERVICES AND LIMITATIONS

Preventive health care, including routine foot care (e.g., trimming toenails for the prevention of ingrown toenails); other hygienic and preventive maintenance care, such as cleaning and soaking the feet; and any other services performed in the absence of localized illness, injury, or symptoms involving the foot are not covered.

An exception to this rule in which coverage is provided is corrective toenail trimming performed to prevent further complications in a patient who has a systemic condition that has resulted in severe circulating embarrassment or areas of desensitization in the legs or feet. Examples of systemic conditions that may result in severe circulation embarrassment are diabetes mellitus and thrombophlebitis of the lower extremities. The trimming of other diseased toenails where there is not such a systemic condition, such as onycromycotic toenails, is not covered. The trimming of nails for a systemic condition is limited to once every 60 days and must be medically necessary. The systemic condition justifying the toenail trimming must be clearly stated in the progress note for each date of service on which the trimming is performed.

Routine palliative trimming of corns, warts, or calluses (including plantar warts) is generally not covered. The service will be covered, however, if the removal of the corn, wart, or callus is necessitated by the presence of an associated pathological condition, such as cellulitis; any systemic condition that has resulted in severe circulating embarrassment or areas of desensitization of the legs or feet; or any disease whereby the patient's life or limb may be jeopardized if such lesions are not treated. The qualifying condition must be documented in the medical chart for each date of service on which the trimming is performed, and explained in the "Remarks" section of the invoice.

Treatment of flat feet and subluxations, dislocations, strains, imbalance, and other structural misalignment not requiring surgery is not covered except as may be the general medical practice for the correction of a congenital defect identified through the EPSDT program.

Separate charges for surgical assistants and anesthesiologists in connection with office surgery are not covered unless preauthorization has been given by DMAS.

The following services are not covered:

- Separate charges for an office visit or examination on the day of office surgery
- Experimental procedures
- Acupuncture
- Autopsy examinations
- X-rays beyond the confines of the foot and ankle
- Durable medical equipment and expendable medical supplies for home use, as

well as prosthetic devices (including shoes)

- Courtesy calls - visits in which no identifiable service was rendered
- Care provided by mail or telephone
- Unkept or broken appointments
- Procedures for which payment is prohibited by State or federal statute or regulation

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

[Effective Date: January 1989]

The Medicare Catastrophic Act of l988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible only for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY QMB MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." Medicaid does not make payment for any recipient of this group for pharmacy, non-emergency transportation, medical supplies, or any service not covered by Medicare.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges for **all** Medicare covered services **plus** coverage of **all** other Medicaid covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY QMB EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapters III and VI of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid enrolled physician who is not the

~~designated primary provider may provide and be paid for services to these recipients only:~~

- ~~In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient.~~
- ~~On written referral from the primary physician. This also applies to covering physicians.~~

~~The primary care physician must complete a Practitioner Referral Form (DMAS-70) when making a referral to another physician or clinic (see "EXHIBITS" at the end of this chapter for a sample of the form). Appropriate billing instructions for these situations are covered in Chapter V of this manual.~~

~~EXHIBITS~~

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

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REFERRAL PHYSICIAN'S COPY

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

PREAUTHORIZATION REQUEST FOR NON-COVERED NEW DRUG

NOTE: Request must be legible and completed in full for consideration of coverage and reimbursement of non-covered new drugs.

Physician's Name (please print) _____

Provider Number _____ Phone Number _____

Address _____

Recipient Name _____ Medicaid I.D. # _____

1. Drug Name _____ Dosage Form _____ Strength _____

   Dosage Regimen _____

2. List diagnosis/condition for which new drug is to be used. _____

   _____

   _____

3. Reason(s) for request. (Check all applicable blocks.)

   ☐ Drug(s) to treat patient's diagnosis/condition not available.

   ☐ Drug(s) previously used did not result in the desired therapeutic effect.

   List drugs used. _____

   _____

   ☐ Compliance problem with existing drugs in same pharmacologic class.

   ☐ Adverse reaction resulting from previous drug therapy.

   ☐ Contraindication to currently used/approved drugs not observed in use of requested drug. Explain: _____

   _____

   _____

   ☐ Other. Specify: _____

   _____

   _____

Signed _____ Date _____

* Practitioner should keep a copy of the completed form in the patient's record.

** Pharmacy must submit the original of this form with the original claim for each non-covered new drug.

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