KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Podiatry
## Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>BILLING INSTRUCTIONS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7000</td>
<td>Podiatry Billing Instructions</td>
<td>7-1</td>
</tr>
<tr>
<td></td>
<td>Submission of Claim</td>
<td>7-1</td>
</tr>
<tr>
<td>7010</td>
<td>Podiatry Specific Billing Information</td>
<td>7-2</td>
</tr>
</tbody>
</table>

## BENEFITS AND LIMITATIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Benefit</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8100</td>
<td>Copayment</td>
<td>8-1</td>
</tr>
<tr>
<td>8300</td>
<td>Benefit Plans</td>
<td>8-2</td>
</tr>
<tr>
<td>8400</td>
<td>Medicaid</td>
<td>8-3</td>
</tr>
</tbody>
</table>

Forms Section
PART II
PODIATRY PROVIDER MANUAL

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to podiatry providers. It is divided into two subsections: Billing Instructions and Benefits and Limitations.

The **Billing Instructions** subsection gives an example of the billing form applicable to podiatry services. The form is followed by directions for completing and submitting it.

The **Benefits and Limitations** subsection defines specific aspects of the scope of podiatry services allowed within the Kansas Medical Assistance Program.

**HIPAA Compliance**

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General’s Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.
PODIATRY BILLING INSTRUCTIONS

Introduction to the HCFA-1500 CMS-1500 Claim Form Updated 05/07

Podiatry providers must use the HCFA-1500 CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program (KMAP). An example of the HCFA-1500 CMS-1500 claim form is in the Forms section at the end of this manual. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 CMS-1500 claim form to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line by line instructions for completion of the HCFA-1500 CMS-1500 are available in the General Billing Provider Manual, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas  66601-3571
Office Visits:
  Use evaluation and management (E&M) procedure code 99213.
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 11/03

Podiatry services require a copayment of $1.00 per office visit (99213). (Refer to Section 3000 for exceptions.)

Bill all services occurring on the same date on the same claim form. Do not reduce charges or balance due by the copayment amount. This reduction will be made automatically by EDS.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.
8300. Benefit Plan  Updated 08/08

KMAP beneficiaries will be assigned to one or more Medical Assistance benefit plans. The assigned plan or plans will be listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification. Contact the Customer Service Center at 1-800-933-6593 or (785) 274-5990.
PODIATRY SERVICES ARE COVERED FOR KAN BE HEALTHY (KBH) BENEFICIARIES ONLY.

Adult Care Home:
Podiatry services are not allowed in an adult care home (ACH), except for those services rendered to a KBH beneficiary.

ACH Visits:
One routine visit per month is covered.
No other ACH visits are covered on the same day as an ACH history and physical.

Consultations:
Only one initial consultation is covered within a 60-day period for the same consumer by the same provider.

Only one inpatient follow-up consultation is covered within a 10-day period for the same consumer by the same provider.

Only one outpatient follow-up consultation is covered within a 60 day period for the same consumer by the same provider.

Documentation:
To verify services provided in the course of a postpayment review, documentation in the consumer’s medical record must support the service billed.

Hospital Visits:
One inpatient hospital visit per day is covered.

Only one physician will be reimbursed for a patient with a single diagnosis except for consultation. When a patient has two or more diagnoses involving two or more systems where the special skill of two or more physicians are essential in rendering quality medical care, concurrent care is covered for the days when such care is medically necessary and a medical necessity form (Section 4100) is attached.

Office Visits:
One comprehensive office visit is covered per calendar year, per consumer.
8400. Updated 11/03

Surgery:

Ambulatory/Outpatient Surgery:
Only one ambulatory/outpatient surgical procedure is reimbursed per day, per consumer.

Content of Service:
IVs, medications, supplies and injections performed on the same day as an ambulatory outpatient surgery procedure are considered content of service of the surgery and may not be billed separately.

Anesthesia, equipment and supplies, drugs, surgical supplies, etc., are considered content of service of the ambulatory/ outpatient surgical procedure.

Procedures performed in conjunction with an emergency room visit (sutures, minor surgeries, etc.) are considered content of service of the emergency room visit and may not be billed separately. When reimbursement for the procedure is preferred, the CPT code for the procedure performed shall be billed in lieu of the ER visit.

Cosmetic Surgery:
Surgeries that are cosmetic in nature (and related complications) are not covered. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized. (Refer to Section 4300.)

Elective Surgery:
The Medicaid Program will not reimburse for elective surgery unless the procedure is medically necessary and the consumer is a KAN Be Healthy participant. (Refer to Section 2020 for details.)

Minor Surgery:
All office visits, hospital visits and non-emergency outpatient visits for a period of 21 days after minor surgeries are content of service of the surgery.

All office visits and non-emergency outpatient visits rendered on the same day as surgery are content of service of the surgery.
FORMS SECTION

CMS-1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE [ ] MEDICAID [ ]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

8. CITY [ ] STATE [ ]

9. ZIP CODE [ ] TELEPHONE (Include Area Code) [ ]

10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. EMPLOYER'S NAME OR SCHOOL NAME

13. INSURANCE PLAN NAME OR PROGRAM NAME

14. DATE OF CURRENT ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 1st [ ] 2nd [ ] 3rd [ ] 4th [ ]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. MEDICAID REMITTANCE CODE [ ] ORIGINAL REF. NO. [ ]

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

25. FEDERAL TAX I.D. NUMBER [ ] SSN [ ]

26. PATIENT'S ACCOUNT NO. [ ]

27. ACCEPT ASSIGNMENT? YES [ ] NO [ ]

28. TOTAL CHARGE $ 29. AMOUNT PAID $ 30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse are true and complete to the best of my knowledge) ______

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PICA

Signed

NPI

NPI