

Podiatry Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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eManual Contents

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Medicaid Assistance Letters (MAL)

MAL 561

Medical Assistance Letter No 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 561, Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies](#)

MAL 546

Medical Assistance Letter No 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 546, Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms.](#)

MAL 539

Medical Assistance Letter No 539 (October 19, 2007 - Federal delay of requirement for use of tamper-resistant prescription pads), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 539, Changes to the Pharmacy Program Effective October 1, 2007](#)

MAL 535

Medical Assistance Letter No 535 (September 6, 2007 - Changes to the Pharmacy Program Effective October 1, 2007), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 535, Changes to the Pharmacy Program Effective October 1, 2007](#)

MAL 527

Medical Assistance Letter No 527 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 527, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 526

Medical Assistance Letter No 526 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Chiropractic Services e-book.

[Click here to view MAL 526, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

Medicaid Handbook Transmittal Letters (MHTL)

MHTL 3338-10-01 (Five Year Rule Review of Medicaid Podiatry Rules 5101:3-7-01, 5101:3-7-02, 5101:3-7-03 and 5101:3-7-04)

Medicaid Handbook Transmittal Letter (MHTL) No. 3338-10-01

October 29, 2010

TO: All Eligible Providers of Podiatry Services
Directors, County Departments of Job and Family Services
Managed Care Plans

FROM: Douglas E. Lumpkin, Director

SUBJECT: Five year rule review of Medicaid podiatry rules 5101:3-7-01, 5101:3-7-02, 5101:3-7-03 and 5101:3-7-04

Rules changes are effective November 4, 2010

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of the revision of Medicaid rules [5101:3-7-01](#), [5101:3-7-02](#), [5101:3-7-03](#) and [5101:3-7-04](#) in accordance with mandatory five year rule review.

Rule [5101:3-7-01](#), entitled "Eligible providers of podiatric services," provides guidance in regards to provider types authorized to bill for podiatric services offered by the Ohio Medicaid program. This rule was amended to comply with mandatory five year rule review. Changes include updating rule language and general rule formatting corrections based on stakeholder input. Additionally, the term "podiatrist" is being changed to "podiatric physician" and the term "podiatry" or "podiatric" is being changed to "podiatric medicine" to accommodate stakeholder feedback.

Rule [5101:3-7-02](#), entitled "Scope of coverage," details acceptable podiatry procedures that are authorized to be performed and billed to the Ohio Medicaid program by podiatry physicians. This rule was amended to comply with mandatory five-year rule review. Changes include updating rule language and general rule formatting corrections based on stakeholder input. Additionally, the term "podiatrist" is being changed to "podiatric physician" and the term "podiatric" is being changed to "podiatric medicine" to accommodate stakeholder feedback. Lastly, the title of this rule "Scope of coverage" is being changed to "Podiatric medicine: scope of coverage".

Rule [5101:3-7-03](#), entitled "Covered podiatric services and associated limitations," defines specific podiatry codes and examinations which are eligible for reimbursement by the Ohio Medicaid program. This rule was amended comply with mandatory five-year rule review. Changes include updating rule language and general rule formatting corrections based on stakeholder input. Paragraph (E) of this rule was updated to revise existing criteria pertaining to the provision of radiology services by eligible podiatry practitioners. Additionally, the term "podiatrist" is being changed to "podiatric physician" to accommodate stakeholder feedback.

Rule [5101:3-7-04](#), entitled "Podiatry: non-covered services," details examinations and procedures that are not covered by the Ohio Medicaid program. This rule was amended to comply with mandatory five-year rule review. Changes include updating rule language and general rule formatting corrections based on stakeholder input. Additionally, the title of this rule "Podiatry: noncovered services" is being changed to "Podiatric medicine: noncovered services" to accommodate stakeholder feedback.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>. Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates for services other than pharmacy services and the medical supplies listed in this MHTL are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3338-09-02 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3338-09-02

January 8, 2010

TO: All Eligible Podiatrists
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3338-09-01

Medicaid Handbook Transmittal Letter (MHTL) 3338-09-01

February 19, 2009

TO: All Eligible Podiatric Services Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Physician Assistants

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-02, "Scope of coverage" and the rescission and adoption of new OAC rule 5101:3-4-03, "Physician assistants."

OAC rule [5101:3-4-02](#) is titled "Scope of coverage." This amended rule outlines the requirements regarding physician supervision of non-physicians when non-physicians provide Medicaid reimbursable services. This rule is amended to incorporate changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This amended rule updates the reference to the required level of physician supervision of physician assistants so that such reference is consistent with proposed rule 5101:3-4-03, "Physician assistants," of the Administrative Code.

Specifically, this rule removes paragraph (C)(2)(c), which indicated that physician assistants must be "under the general supervision of the physician" in order for Medicaid to reimburse eligible providers for provision of physician assistant services. This amended rule includes a new reference, paragraph (D), to rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code, "Physician assistants." This referenced rule addresses the required level of physician supervision of physician assistants in order for Medicaid to reimburse eligible providers for provision of physician assistant services.

OAC rule [5101:3-4-03](#) is titled "Physician Assistants." This new rule incorporates changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This new rule explains the conditions under which Ohio Medicaid will reimburse Medicaid providers for physician assistant services.

This new rule:

- Provides new and updated definitions as well as definitions by reference;
- Provides updated references to the Section 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code that govern the practice of Physician Assistants in Ohio;
- Removes requirements that a patient new to a physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant;
- Removes requirements that an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition;
- Removes requirements that medical records for patients new to a physician's practice and medical records for established patients with a new condition must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant;
- Clarifies that Medicaid providers will not be reimbursed for visits provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic; and
- Clarifies that direct reimbursement is not available for services provided by a hospital employed physician assistant. The reimbursement for the services provided by the physician assistant is bundled into the facility payment made to the hospital.

This rule does not include information regarding Medicaid coverage of Pharmacy, Durable Medical Equipment, and Laboratory Services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for Ohio Medicaid requirements related to these topics.

Web Page:

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- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers"; and
- (3) Selecting "[5101:3-1-60](#) Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
800-686-1516

MHTL 3338-08-02

Medicaid Handbook Transmittal Letter (MHTL) 3338-08-02

July 17, 2008

To: All Eligible Providers of Podiatric Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Medicaid Program Fee Increases

Effective July 1, 2008

Medicaid Reimbursement-OAC 5101:3-1- 60

The Department is pleased to announce that the Medicaid maximums for certain codes will be increased as part of the Governor's biennium budget. An aggregate 3% increase is being implemented for claims with dates of service on and after July 1, 2008.

The Medicaid maximums for selected CPT codes have been raised. If the Medicaid maximum was over the Medicare price, the Medicaid maximum was lowered to the 2007 Medicare fee. For many codes, the Medicaid maximum remains unchanged.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1- 60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>.

The full text of this rule amendment and the accompanying appendix DD to this rule can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Podiatry Services handbook.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Podiatry services"; and,
- (3) Selecting this MHTL number from the "Table of Contents" pull-down menu.

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar/>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3338-06-02

Medicaid Handbook Transmittal Letter (MHTL) 3338-06-02

September 26, 2006

TO: All Eligible Providers of Podiatric Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Podiatry Policy Updates: Surgery and J code updates

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce amendments being made to Ohio Administrative Code (OAC) 5101:3-1-60, Medicaid reimbursement, and 5101:3-4-22, Surgical services.

Note: Rules 5101:3-1-60 and 5101:3-4-22 are in a proposed status and are scheduled to become effective October 15, 2006 for dates of service on or after October 15, 2006. The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Podiatry Services handbook.

EFFECTIVE OCTOBER 15, 2006

Medicaid reimbursement: 5101:3-1-60

Amendments to this rule relative to podiatry services were updates to Appendix DD of the rule to include quarterly pricing updates from the Centers for Medicare and Medicaid Services on J-drug codes prices.

Surgical services: 5101:3-4-22

This rule was amended to include a new appendix. Appendix A of this rule specifies which surgical procedures the Department considers to be bilateral, multiple surgeries, or whether an assistant at surgery is reimbursable. Procedure codes listed in appendix A are indicated with an "x" in the column that corresponds to whether bilateral, multiple surgery, or assistant at surgery price reductions apply.

Multiple surgeries:

Effective for claims submitted on and after October 15, 2006, surgical procedures marked by an "x" in the appendix in the column called "multiple surgery", will be subject to multiple surgery price reductions.

For multiple procedure pricing, a definition has been added to delineate which procedure will be considered the primary procedure. New language states that the primary procedure is considered to be the surgical procedure that has the highest Medicaid maximum listed in appendix DD of rule 5101:3-1-60 of the Ohio Administrative Code.

Surgical procedure codes that are not considered multiple surgery will be paid at the lesser of the billed charge or the Medicaid maximum regardless of whether the codes are submitted with another surgical procedure that had an "x" in the multiple surgery column of appendix A to the surgery rule.

The Department will begin to recognize the 51 modifier on codes that are considered multiple surgery. This modifier signifies a multiple procedure. However, usage of this modifier will not have an effect on the level of reimbursement. If a claim is submitted with the 51 modifier but the surgical code is not marked as multiple surgery in appendix A in the surgery rule, the claim with the 51 modifier will be denied.

Bilateral surgery:

For claims submitted on or after the effective date of this rule, bilateral surgery pricing will apply to procedures indicated with an "x" in the corresponding column for bilateral surgery in appendix A to the surgery rule.

Bilateral procedures should be billed to the Department using the appropriate code for the procedure modified by the modifier 50. For example, 6943350 would mean a tympanostomy was performed on both ears. Code

69433 billed without a modifier would mean the procedure was performed on one ear. If the procedure code is billed unmodified, the department will not reimburse for the procedure as a bilateral procedure.

The Medicaid maximum for bilateral procedures is one hundred fifty per cent of the Medicaid maximum allowed for the same procedures performed unilaterally when the code is billed with the 50 modifier.

Assistants at surgery:

For claims submitted on or after October 15, 2006, assistant at surgery pricing will apply to procedures indicated with an "x" in the corresponding column for assistant at surgery in appendix A to this rule.

For reimbursement, providers must bill the appropriate code for the primary surgical procedure modified by 80.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of rule 5101:3-4-22, please complete the attached JFS 03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3338-06-01

Medicaid Handbook Transmittal Letter (MHTL) 3338-06-01

June 30, 2006

TO: All Eligible Providers of Podiatry Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Podiatry Policy Updates: 5101:3-1-60 and 5101:3-4-13

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce amendments being made to Ohio Administrative Code (OAC) Rules 5101:3-1-60, Medicaid reimbursement and 5101:3-4-13, Therapeutic injections (including trigger point injections) and prescribed drugs.

Note: Rule 5101:3-4-13 is scheduled to become effective July 1, 2006 for dates of service on or after July 1, 2006. Rule 5101:3-1-60 is in proposed status and is scheduled to become effective July 15, 2006 for dates of service on or after July 15, 2006. The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Podiatric Services handbook.

EFFECTIVE JULY 1, 2006

Therapeutic injections (including trigger point injections) and prescribed drugs:

Rule 5101:3-4-13

This rule has been amended to delineate policy relating to trigger point injections. Paragraph (B) of this rule defines trigger point injections, details the criteria for reimbursement, defines documentation requirements, and sets limitations for these services. Other changes are for clarifications of existing policy.

Definition:

A trigger point injection is one of the many modalities utilized in the management of chronic pain. A trigger point is an area of hyperexcitability where the application of stimulus will provoke pain to a greater degree than in the surrounding area. Injection of a corticosteroid mixed with a local anesthetic or a local anesthetic by itself, directly into the affected body part may alleviate or treat inflammation and pain. The treatment goal should be to treat not just the symptom of pain but also the cause of the pain.

Criteria for reimbursement

All of the following coverage criteria must be met before this service can be reimbursed by the department:

- The services must be considered medically necessary;
- The conditions for reimbursement for therapeutic injections listed in paragraph (A)(3) of rule 5101:3-4-13 must be met;
- The patient's diagnosis must support the need for the service; and,
- There must be documentation in the patient's medical record to confirm that a trigger point injection was provided.

Documentation:

The following items must be documented in the patient's medical record:

- A proper evaluation including a patient's history and physical examination leading to diagnosis of a condition requiring a trigger point;
- Identification of the affected muscle(s);
- Reasons for selecting therapeutic option;

- The muscles injected and the amount of injections;
- Frequency of injections required;
- The name of the medication used in the injection;
- For a follow up visit, the results of the initial visit; and,
- Documentation that supports the medical necessity of the service.

Limitations

- In accordance with CPT guidelines, only one unit of service will be reimbursed for codes 20552 and 20553 per patient, per date of service, per provider regardless of the number of sites or regions injected. Units of service are not determined by the number of injections given.
- Codes 20552 and 20553 are not to be billed collectively for the same patient on the same date of service. In accordance with CPT, only one of these codes will be reimbursed per date of service, per provider.
- Trigger point injections should be repeated only if reasonable and medically necessary. For dates of service on or after the effective date of this rule, trigger point injections of local anesthetic and/or steroids will be limited to a maximum of eight dates of service per patient per year. Claims with injections exceeding this limit in a calendar year period will be denied.

EFFECTIVE JULY 15, 2006

Medicaid reimbursement: 5101:3-1-60

The Medicaid reimbursement rule is being amended to reflect price changes for J codes and immunization codes, to add the new vaccine code for rotavirus, and to revise miscellaneous CPT or HCPCS codes. The changes can be found in appendix DD of the rule.

Edit for multiple unit billing:

It has come to the Department's attention that some providers are billing multiple units for a single evaluation and management CPT code, e.g., a hospital visit or an office visit. The Department's billing instructions, which can be found at <http://emanuals.odjfs.state.oh.us/emanuals>, specify that one unit should be billed in most cases (exceptions are anesthesia time, time-based codes, etc.). The Department will begin denying claims for codes in the range of 99201-99440 (excluding time-based codes and add-on codes) and 99050-99051 when multiple units are billed for a single code. When billing evaluation and management codes, providers must enter the CPT code for each evaluation and management service provided on a single line of the claim and must have only one unit for that service (e.g. a recipient has a three day hospital stay, the provider should bill code 99232, three times, on three different lines, showing each date of service on a single line of the claim). Please be advised that Ohio Medicaid does not accept billing for a span of care covering a range of dates on a single claim line of a professional claim. Claims containing evaluation and management codes with multiple units will be denied and providers will have to resubmit with only one unit per code. Should you have questions, please call Provider Network Management at 1-800-686-1516.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of rule 5101:3-4-13, please complete the attached JFS03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
 The Provider Network Management Section
 P.O. Box 1461
 Columbus, Ohio 43216-1461
 Toll free telephone number 1-800-686-1516

MHTL 3338-05-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3338-05-01

August 11, 2005

TO: All Eligible Providers of Podiatry Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rules 5101:3-7-01 Eligible providers of podiatric services, 5101:3-7-02 Scope of coverage, 5101:3-7-03 Covered podiatric services and associated limitations and 5101:3-7-04 Podiatry: noncovered services

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revisions to the podiatry program rules.

The podiatry rules were refilled primarily in accordance with Ohio Revised Code Section 119.032 which mandates that each state agency is required to review its rules a minimum of once every five years. No changes were made to actual procedural or service coverage components of OAC rules 5101:3-7-01, 5101:3-7-02, 5101:3-7-03 and 5101:3-7-04 were made at this time. Additionally, these rules were amended to include updates to terminology and procedures consistent with the most current Legal Service Commission (LSC) Rule language as well as corrections to minor grammatical errors.

Prior Authorization

Prior authorization requests submitted must include an official JFS 03142, rev. 02/2003 form completed with sufficient information to support the medical necessity of the consumer for the DME item being requested.

DME Question Line and Mailbox

In February 2005, the department established a DME Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

Prior Authorization Form - JFS 03142, rev. 02/2003

The department recommends that providers view this form and the entire text of the DME and podiatry rules in the Durable Medical Equipment and podiatry services handbooks at:

<http://emanuals.odjfs.state.oh.us/emanuals>

These forms and other department forms can also be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MHTL including all attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

Prior Authorization Form - JFS 03412, rev. 02/2003

Miscellaneous Medicaid Handbook Transmittal Letters (MHTL)

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

[Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance \(DMA\) Program and the Rescission of Ohio Administrative Code \(OAC\) Rule 5101:3-23-01](#)

Podiatry Program Rules

5160-7-01 Eligible Providers of Podiatric Services

~~*Formerly*~~ 5101:3-7-01 Eligible Providers of Podiatric Services

MHTL3338-10-01

Effective Date: November 4, 2010

Most Current Prior Effective Date: August 15, 2005

(A) Definitions.

- (1) A doctor of podiatric medicine is included within the definition of "physician" but only in respect to functions ~~he/she~~ he or she is legally authorized to perform ~~under~~ as defined in section 4731.51 of the Revised Code.
- (2) ~~"Podiatrist"~~ Podiatric physician means an individual currently licensed under state of Ohio law or another state's law to practice podiatry.
- (3) Interns and residents of ~~podiatry~~ podiatric medicine are explicitly excluded from the definition of ~~"podiatrist"~~ podiatric physician and are covered as part of hospital services. This exclusion applies whether or not the intern or resident may be authorized to practice as a ~~podiatrist~~ podiatric physician under the laws of the state in which ~~he performs his services~~ services are performed. Residents having a staff or faculty appointment or designated as a fellow are also excluded from the definition of ~~podiatrist~~ podiatric physician.
- (4) "Podiatric group practice" means a professional association organized under ~~sections 1785.04 to 1785.08~~ Chapter 1785. of the Revised Code for the purpose of providing podiatric services.
- ~~(5) Current procedural terminology (CPT) whenever referenced in this chapter will be defined in accordance with rule 5101:3-1-19.3 of the Administrative Code.~~

(B) All ~~podiatrists~~ podiatric physicians currently licensed to practice podiatry under sections 4731.51 to 4731.61 of the Revised Code are eligible to participate in Ohio's medicaid program and provide podiatric medicine services upon execution of an Ohio medicaid provider agreement.

(C) A professional association (podiatric medicine group practice) is ~~also~~ also considered eligible to participate in Ohio's medicaid program if it is an association organized under ~~sections 1785.04 to 1785.08~~ Chapter 1785. of the Revised Code for the purpose of providing podiatric medicine services.

(D) ~~Podiatrists~~ Podiatric physicians licensed under another state law to practice medicine and surgery are eligible to participate in Ohio's medicaid program and provide covered podiatric medicine services as long as:

- (1) The services are rendered to eligible Ohio ~~recipients~~ consumers in the state in which the provider is licensed to practice; and
- (2) The provider of podiatric medicine services has a current valid provider agreement with the Ohio department of job and family services (ODJFS).

Effective: 11/04/2010

R.C. 119.032 review dates: 07/29/2010 and 11/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 10/25/2010

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/30/77, 5/9/86, 2/1/90, 8/15/05

MHTL3338-10-01

Effective Date: November 4, 2010

Most Current Prior Effective Date: August 15, 2005

- (A) ~~Podiatrists~~ Podiatric physicians may perform covered services (as defined in Chapter 5101:3-7 of the Administrative Code) which consist of the medical, mechanical and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma. The ~~podiatrist~~ podiatric physician may also treat the local manifestation of systemic disease as they appear in the hand and foot, but the ~~patient~~ consumer must be concurrently referred to ~~a doctor of medicine or a doctor of osteopathic medicine and surgery~~ an eligible prescriber for treatment of the systemic disease itself.
- (B) Podiatric medicine services provided by ~~nonphysicians~~ non-physicians under the direct and general supervision of ~~podiatrist~~ a podiatric physician are covered in accordance with rule 5101:3-4-02 of the Administrative Code.
- (C) Hospital-based ~~podiatrists~~ podiatric physicians and surgeons are covered in accordance with rule 5101:3-4-01 of the Administrative Code.
- (D) Podiatric medicine services provided in a teaching setting are covered as set forth in paragraphs (A) to (D)(2), (E)(1) and (F) of rule 5101:3-4-05 of the Administrative Code.
- (E) Podiatric medicine services provided in a long-term care setting are covered as detailed in rule 5101:3-3-19 of the Administrative Code.
- (F) Podiatric medicine services provided by a physician assistant are covered in accordance with rule 5101:3-4-03 of the Administrative Code.
- (G) By report services are covered in accordance with rule 5101:3-4-02.1 of the Administrative Code. In addition, a report must be provided documenting the following:
- (1) Complete description of the services or procedures;
 - (2) Diagnosis, both preoperative and postoperative;
 - (3) Size, location, and number of lesions;
 - (4) Indication of primary, secondary, or tertiary procedure;
 - (5) The nearest similar current procedural terminology (CPT) code whenever possible;
 - (6) Estimated number of visits for follow-up; and
 - (7) Operative time.

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Rule Amplifies: 5111.01, 5111.02, 5111.021

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MHTL3338-10-01

Effective Date: November 4, 2010

Most Current Prior Effective Date: March 29, 2007

(A) Visit limitations.

(1) Visits are covered in accordance with ~~rule rules~~ 5101:3-3-19 and ~~paragraphs (A) to (F), (H) to (J) and (M) of~~ rule 5101:3-4-06 of the Administrative Code.

(2) In addition, the following limitations apply:

(a) Reimbursable evaluation and management services shall be limited to the following ~~current procedural terminology (CPT)~~ codes:

99201 to 99203

99211 to 99213

99221 to 99222

99231 to 99232

99238

99241 to 99243

99251 to 99253

99304 to 99328

99341 to 99342

99347 to 99348

~~(b) Emergency or critical care services shall be considered on a by-report basis.~~

~~(e)~~(b) Reimbursement by the department is limited to one long term care facility (LTCF) visit per month.

(B) Therapeutic injections and prescribed drugs are covered in accordance with rule 5101:3-4-13 of the Administrative Code. In addition, vitamin B-12 injections for strengthening tendons, ligaments, or other components of the foot are not covered.

(C) Surgeries.

(1) Surgeries are covered in accordance with rules 5101:3-4-09, 5101:3-4-22 and 5101:3-4-23 of the Administrative Code.

(2) In addition, the following limitation applies: reimbursement for debridement of nails is limited to a maximum of one treatment within a sixty-day period.

(D) Laboratory services are covered in accordance with Chapters 5101:3-4 and 5101:3-11 of the Administrative Code.

(E) Radiology services.

(1) Radiology services are covered in accordance with Chapters 5101:3-4 and 5101:3-11 of the Administrative Code.

(2) In addition, the following radiology services are not covered as podiatric medicine services:

(a) Bilateral x-rays when only a unilateral condition or surgery is reported, unless documented as medically indicated;

- (b) X-rays in excess of ~~two~~three views unless the necessity due to trauma or infection is fully documented;
- (c) X-rays for soft tissues unless for reasons of infections which is fully documented;
- (d) Postoperative x-rays unless there is bone involvement necessitating the surgical procedure or cases of suspected postoperative infections; and
- (e) The use of x-rays or radium for therapeutic purposes.

(F) Physical medicine services.

- (1) Physical medicine services are covered in accordance with Chapter 5101:3-8 of the Administrative Code.
- (2) In addition, the following limitations apply:
 - (a) Reimbursement for physical medicine services provided within the scope of practice of podiatric medicine and surgery as specified in the Revised Code is limited to acute conditions only. For those recipients in which the disease has reached a chronic stage, reimbursement will be made only for the periods of acute exacerbation of the disease.
 - (b) Range of motion studies may not be billed separately from an examination of the foot, unless substantiated by a complete report.

(G) Medical supplies and durable medical equipment (DME).

- (1) A ~~podiatrist~~podiatric physician may not be separately reimbursed for medical supplies and equipment (e.g., tape, dressing, or surgical trays) utilized in podiatrist's office, clinic, or patient's home during a podiatric visit.
- (2) A ~~podiatrist~~podiatric physician may be reimbursed for medical supplies and medical equipment dispensed in the ~~podiatrist's~~podiatric physician's office, clinic or patient's home for use in the patient's home, if the ~~podiatrist~~podiatric physician has a "supplies and medical equipment" category of service ~~(32)~~.
- (3) The scope and extent of coverage for medical supplies and durable medical equipment, including orthopedic shoes and foot orthoses, are covered in Chapters 5101:3-4 and 5101:3-10 of the Administrative Code.

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Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 5/9/86, 5/19/86, 9/1/89, 2/1/90, 4/1/92 (Emer), 7/1/92, 1/1/01, 8/15/05, 12/29/06 (Emer), 3/29/07

MHTL3338-10-01

Effective Date: November 4, 2010

Most Current Prior Effective Date: August 15, 2005

- (A) The following services are noncovered:
- (1) All services exceeding the policies and limitations defined in Chapters 5101:3-4 and 5101:3-7 of the Administrative Code.
 - (2) Services determined by the department as not medically necessary as defined in Chapter 5101:3-1 of the Administrative Code.
 - (3) Services of a preventive nature.
- (B) In addition, the following services are noncovered, unless a **recipient consumer** has a localized infection or is under the care of ~~a doctor of medicine or a doctor of osteopathic medicine and surgery~~ **an eligible prescriber** for a metabolic disease such as diabetes mellitus, or another condition that may result in a circulatory impairment or desensitization in the legs or feet:
- (1) Examinations and diagnostic services associated with routine foot care performed in the absence of a localized illness, symptoms or injury;
 - (2) Cutting or removal of corns and calluses;
 - (3) Nail trimming, cutting or clipping of nails not associated with nail surgery, unless a systemic condition is present such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional **an eligible prescriber**;
 - (4) Foot care provided for hygienic services;
 - (5) The treatment of uncomplicated, chronic foot conditions such as flat feet or a subluxated structure in the foot; and
 - (6) Treatment of mycotic nails for an ambulatory and nonambulatory **patient consumer** unless the **physician eligible prescriber** attending the patient's mycotic condition documents that:
 - (a) There is clinical evidence of onychomycosis of the toenail; and
 - (b) The **patient consumer** has mycosis/dystrophy of the toenail causing secondary infection and/or pain that results or would result in marked limitation of ambulation and require the professional skills of a podiatrist **podiatric physician**.

Effective: 11/04/2010

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Date: 10/25/2010

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Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 5/19/86, 9/1/89, 2/1/90, 1/1/01, 8/15/05

Billing Instructions

Click [here](#) to view the Billing instructions eManual.

Notice

A Podiatry Services provider handbook is currently not available.

Below please find Medicaid Handbook Transmittal Letters (MHTLs), Medical Assistance Letters (MALs) and Ohio Administrative Code (OAC) rules regarding Podiatry Services and links to the OAC (found in the Legal Services collection).