Ohio Administrative Code

Rule 5160-7-01 Podiatry services.

Effective: April 1, 2021

(A) For the purpose of this rule the following definitions apply.

(1) "Doctor of podiatric medicine" (or "podiatric physician" or "podiatrist") is as described in section 4731.51 of the Revised Code.

(a) Doctors of podiatric medicine are deemed to be physicians only in respect to functions they are legally authorized to perform in accordance with section 4731.51 of the Revised Code and rule 4731-20-02 of the Administrative Code.

(b) For purposes of medicaid coverage and payment, an intern or resident of podiatric medicine is not a podiatric physician. This exclusion applies even if an intern or resident is authorized to practice as a podiatric physician under the laws of the state in which services are performed or a resident holds a staff or faculty appointment or is designated as a fellow. For purposes of medicaid coverage and payment, an intern or resident of podiatric medicine is not a podiatric physician.

(2) "Podiatric group practice" is a professional association organized under Chapter 1785. of the Revised Code for the purpose of providing podiatric medicine services.

(B) Coverage.

(1) Services and procedures performed by a doctor of podiatric medicine that are within the scope of practice of a podiatric physician are considered to be physician services. They are subject to and are covered in accordance with applicable medicaid rules in the Administrative Code concerning physician services.

(2) The services of interns and residents of podiatric medicine rendered in a hospital setting are covered as hospital services in accordance with Chapter 5160-2 of the Administrative Code.

(3) Podiatric medicine services provided by a physician assistant are covered in accordance with rule 5160-4-03 of the Administrative Code.

(4) Podiatric medicine services provided by an advanced practice registered nurse are covered in accordance with rule 5160-4-04 of the Administrative Code.

(C) Constraints and limitations.

(1) A "by report" podiatric medicine service or procedure is covered in accordance with rule 5160-1-60.4 of the Administrative Code.

(2) Payment for evaluation and management (E&M) services is limited to the following services:

(a) Professional services of the following types necessitating straightforward medical decision-making or medical decision-making of low, moderate, or high complexity:

(i) Office or other outpatient visit;

(ii) Hospital inpatient services;

(iii) Office or outpatient consultations;

(iv) Inpatient consultations;

(v) Nursing facility services;

(vi) Domiciliary, rest home (e.g., boarding home), or custodial care services;

(vii) Home services; and

(b) Hospital discharge services, thirty minutes or less.

(3) Payment for the debridement of nails is limited to one treatment per sixty-day period.

(4) Payment may be made for the following services only if an individual has a localized infection; is under the care of another healthcare practitioner for a metabolic disease such as diabetes mellitus or another condition that may result in circulatory impairment or desensitization in the legs or feet; or has a systemic metabolic, neurologic, or peripheral vascular disease or condition that may require scrupulous foot care by another healthcare practitioner:

(a) Examinations and diagnostic services associated with routine foot care performed in the absence of a localized illness, symptoms, or injury;

(b) Cutting or removal of corns and calluses;

(c) Trimming, cutting, or clipping of nails not associated with nail surgery;

(d) Foot care provided for hygienic purposes; and

(e) Treatment of uncomplicated, chronic foot conditions such as flat feet or a subluxated structure in the foot.

(5) Payment may be made for the treatment of mycotic toenails only if the healthcare practitioner attending the mycotic condition furnishes the podiatric physician with clinical evidence of at least one of the following conditions:

(a) Onychomycosis of the toenail; and

(b) Mycosis or dystrophy of the toenail causing secondary infection or pain that has resulted or could result in marked limitation of ambulation.

(6) Payment may be made for the following radiology services as podiatric medicine services only if the indicated criterion is fully documented:

(a) A bilateral radiograph for a unilateral condition or surgical procedure when it is medically indicated;

(b) Radiographs in excess of three views when trauma or infection is present;

(c) A radiograph of soft tissue when infection is present; and

(d) A postoperative radiograph when bone involvement necessitated the surgical procedure or postoperative infection is suspected.

(7) Payment for physical medicine services is limited to acute conditions. When a disease or condition has reached a chronic stage, payment may be made only for services or procedures performed during periods of acute exacerbation.

(8) Payment may be made for a range-of-motion study separately from an examination of the foot only if the need is substantiated by a complete report.

(9) Payment may be made for vaccinations administered within a podiatrist's normal scope of practice in accordance with state law and rule 5160-4-12 of the Administrative Code.

(10) The following services are not covered as podiatric medicine services:

(a) Vitamin B-12 injection for strengthening tendons, ligaments, or other components of the foot;

(b) Medical supplies and equipment (e.g., tape, dressing, surgical trays) that are provided during a podiatric medicine visit and are not intended for take-home use; and

(c) The use of radiography or radioactive material for therapeutic purposes.