PODIATRIC SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Podiatrists who meet the licensure and certification requirements of SDCL § 38-8-6 are eligible for payment for podiatric services.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary; and
- The recipient must be eligible.

The manual also includes non-discrimination requirements providers must abide by.

Covered Podiatry Services
Covered podiatry services are listed in the department's podiatric services fee schedule. The following coverage limits apply:

- Stock orthopedic shoes are covered for children age 20 or younger. Orthopedic shoes are only covered for recipients age 21 or older if a shoe is built into a leg brace;
- Foot inserts and arch support for recipients age 21 and older are covered when submitted with documentation showing it is permanently attached to a shoe or leg brace.
- Durable medical equipment such as crutches or pneumatic compressors when furnished incidental to a podiatrist's service.
- Surgical correction of a subluxated foot structure is only covered if it is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an inducted or associated symptomatic condition;
- Routine foot care including cutting or removing corns or calluses, trimming nails, hygienic and preventative maintenance care, using skin creams to maintain the skin tone of ambulatory and bedfast patients are only covered if there is a localized illness, injury, infection, eczema, or the individual has been diagnosed with metabolic, neurologic or peripheral vascular disease;
- Treatment of a fungal (mycotic) infection is only covered if there is clinical evidence of mycosis of the toenail and compelling medical evidence documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, if non-ambulatory, the patient has a condition that is likely to result in significant medical complication in the absence of treatment.

Referrals
Recipients in a Care Management Program are not required to obtain a referral to see a podiatrist. Any podiatry services provided to a resident of a long-term care facility must be the result of a self-referral, a referral by a nurse who is employed by the facility, or a referral by the recipient's family, guardian, physician, or other licensed practitioner.

NON-COVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Podiatry Services
The following podiatry services are not covered:

- Treatment of flatfoot;
- Surgical or nonsurgical treatment of subluxations or the foot undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity; and
- Routine footcare that is for cosmetic purposes or not medically necessary.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Podiatric Required Documentation
Foot inserts and arch support for recipients age 21 or older must be submitted with documentation showing it is permanently attached to a shoe or leg brace. Orthopedic shoes for recipients age 21 or older must be submitted with the prescription showing that the shoe is built onto a leg brace.

Documentation describing the item and demonstrating medical necessity must be submitted with the following “Not Otherwise Specified” procedure codes:

- L1499
- L2999
- L3999
- L5999

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
A claim must be submitted at the podiatrist's usual and customary charge. Payment is limited to the lesser of the provider's usual and customary charge or the fee contained on the department's Podiatric Services fee schedule. If no fee is listed, payment is limited to 40 percent of the provider's usual and customary charge. If no fee is listed for orthopedic shoes, payment is limited to 75 percent of the provider’s usual and customary charge. If a provider performs bilateral or multiple surgeries during the same operating session, the department follows the payment methodology established in ARSD 67:16:02:03.01.

Place of Service Site Differential

Effective for claims with dates of service on and after July 1, 2026, South Dakota Medicaid's maximum allowable reimbursement rate for physicians' services in some instances differs depending on if the service is provided in a facility or non-facility settings. For applicable procedure codes, the place of service is derived from the Place of service (POS) code entered in Block 24 of the CMS 1500 claim form. Non-Facility and Facility place of service code designations are provided in the General Coverage Principles manual. The rate for facility or non-facility services is published on the Departments' Fee Schedule website at https://dss.sd.gov/medicaid/providers/feeschedules/.

Claim Instructions

Claims for professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our website. If a provider performed bilateral or multiple surgeries during the same operative session, the applicable modifier referenced in ARSD 67:16:02:03.01 must be used.

DEFINITIONS

1. "Flatfoot," a condition in which one or more arches in the foot have flattened out;

2. "Podiatrist," an individual who meets the licensure and certification requirements of SDCL 36-8-6 and who performs the acts allowable under SDCL 36-8-1; and

3. "Subluxations of the foot," partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **What type of documentation is required for a recipient age 21 or older to have orthopedic shoes?**

   The prescription must indicate that the shoe is permanently attached to a leg brace. If the shoe is not permanently attached to a leg brace, it is not covered.

2. **If Medicare pays for diabetic shoes for a dual eligible recipient, is documentation required to receive payment from South Dakota Medicaid?**

   No. If the service is covered through Medicare, South Dakota Medicaid will pay the co-insurance and/or the deductible on the Medicare crossover claim.