Research Protocol for Medicaid Coverage for Podiatric Care: A National Survey

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I. Date of Protocol: October 2020

II. Scope: Collect, code, and analyze state laws, regulations, and agency documents authorizing Medicaid coverage for podiatric services. Medicaid is a joint federal-state program which provides healthcare coverage for low-income Americans. Podiatry is an optional service that states are free to provide in their individual state plans. This cross-sectional dataset captures important features of state coverage for podiatric services in effect as of October 1, 2020. The jurisdictions selected for measurement are the 50 states and the District of Columbia.

III. Primary Data Collection


b. Dates covered in the dataset: This is a cross-sectional dataset analyzing state coverage for podiatric services laws as they are in effect at one point in time, October 1, 2020. The effective date listed for each state is the date of the most recent version of the law or regulation within that state. If more than one law or regulation is included in the legal text for a state, the effective date reflects the date of the most recently amended or enacted law or regulation within the legal text.

c. Data Collection Methods: The researchers building this dataset consisted of two research staff members and one principal investigator. Westlaw Next was used to identify state statutes and regulations. Secondary sources included state agency websites and program materials, Medicaid State Plan Amendments, and Medicaid Benefits: Podiatrist Services (Kaiser Family Foundation). Information was also provided by the American Podiatric Medical Association.

d. Databases Used: Research was conducted using Westlaw Next; state-specific legislative and executive department websites; and secondary sources such as state Medicaid agency websites, published materials such as participant and provider manuals.
e. **Search Terms:**
   i. Keyword searches:
      a. “Podiatry”
      b. "Podiatrist"
      c. "Podiatric"
      d. “Podiatr*”
   ii. Keyword searches were used to identify relevant statutes and regulations. Search results were screened to capture only information related to Medicaid coverage for podiatry by examining the headings, chapter, section titles, and text. Search results related to topics such as state licensure, professional board oversight, and scope of practice were excluded.
   iii. Once all the relevant statutes and regulations were identified for a jurisdiction, the text was saved to a jurisdiction-specific folder on a shared drive accessible only to the research team.
   iv. In instances where data were limited or non-existent in statutes and regulations, the same keyword search terms were executed on state Medicaid agency web pages. Relevant documents were collected (e.g.: provider billing manuals, fee schedules, member handbooks, state plan amendments, agency training documents) and added to the corresponding jurisdictional folder on the shared drive.
   v. A summary document was created for each jurisdiction using the information collected and stored on the shared drive.
   vi. Two Master Sheets were created for each jurisdiction with each variable.
   vii. The coding team consisted of two researchers. Each researcher independently populated a separate Master Sheet for all 51 jurisdictions using the collected information. Once the independent coding was completed, the researchers met and compared their entries for each variable in each jurisdiction. Any divergences were discussed and, if possible, a final coding decision was made. If it was not possible to resolve the differences, the issue was discussed at a weekly meeting with the principal investigator. If needed, additional research would be conducted including reaching out to state Medicaid agencies directly.

f. **Initial Returns and Additional Inclusion or Exclusion Criteria:** Included laws pertaining to Medicaid coverage for podiatry.

   i. The following variables were included in the Medicaid coverage for podiatry services dataset:
      - Are podiatric services covered for all classes of Medicaid beneficiaries?
      - Are there categorical limitations on coverage of podiatric services?
      - Is the frequency of podiatric visits limited over a specified period?
      - Are there explicit limitations on coverage of routine foot care?
Are there explicit limits on the number of routine foot care visits allowable per specified period?
Is prior authorization explicitly required for any podiatric services?
Are out-of-pocket costs indicated for podiatric services?
Are there podiatric services that are explicitly not covered?
May podiatric services listed as “non-covered” be covered in instances of medical necessity?

The following variables were excluded in the Medicaid coverage for podiatry services dataset:
- What is the state Medicaid program’s reimbursement structure (fee-for-service vs. value-based/bundled payments)?

IV. Coding

a. Development of Coding Scheme: Researchers first reviewed previous attempts by Kaiser Family Foundation (KFF) and the American Podiatric Medical Association (APMA) to gather data on the subject. With those efforts as a starting point, additional variables of interest were added to the draft coding table. Using policy-surveillance techniques, the team conducted a five-state survey collecting all available documentation from the individual jurisdictions and attempted to populate the coding table. The coding scheme was adjusted and another five jurisdictions were collected. This iterative process repeated for approximately 20 jurisdictions until researchers were satisfied that all available and significant data were being captured. It was also determined that some information (e.g. detailed information on individual Managed Care Organization coverage), while potentially valuable, would have required more resources than available.

b. Coding methods: Below are specific rules used when coding the questions and responses in the state podiatric service laws dataset:

**Question:** “Are podiatric services covered for all classes of Medicaid beneficiaries?”
- States were coded as “Yes” if there was a law, regulation, or program document that explicitly listed podiatry as a covered service without any documented categorical limitations to any class of Medicaid beneficiary.
- States were coded as a “No” if there were explicitly stated limitations on coverage of podiatric services for any class of Medicaid beneficiary.
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Are there categorical limitations on coverage of podiatric services?”
- States were coded “No” if the answer to the previous question (“Are podiatric services covered for all classes of Medicaid beneficiaries?”) is “Yes”.
- States were coded “Covered for Qualified Medicare Beneficiaries (QMBs)” if the law or program documents explicitly stated that podiatric services were covered for QMBs.
- States were coded “Covered for CHIP or EPSDT enrollees” if the law or program documents explicitly stated that podiatric services were covered for CHIP and/or EPSDT enrollees.
- States were coded “Other” in instances where coverage of podiatric services was limited to a class of Medicaid beneficiary not captured by QMB and EPSDT/CHIP categories (e.g.: age-based limitations, coverage limited to beneficiaries enrolled in alternative benefit plans, etc.)
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Is the frequency of podiatric visits limited over a specified period?”
- States were coded “No” if the law and program documents did not explicitly specify limitations on the frequency of visits for podiatric services.
- States were coded “No” if the law and program documents explicitly indicated that podiatric services are covered without limitations.
- States were coded “Yes, all visits” if the law or program documents outlined explicit frequency limitations on general podiatric visits (e.g.: “Podiatry services shall be limited to 4 visits per recipient per state fiscal year.”).
- States were coded “Yes, all visits” if the law or program documents outlined explicit frequency limitations on visits for all Medicaid-enrolled providers in states where podiatrists are covered providers under the state plan (e.g.: “A doctor of podiatric medicine acting within their scope of practice and providing services pursuant to subdivision (a) is subject to the same Medi-Cal billing and services policies as required for a physician and surgeon, including, but not limited to, a maximum numerical service limitation in any one calendar month.”)
- States were coded “Yes, for specific services (e.g.: routine foot care, debridement of nails, etc.)” if the law or program documents outlined explicit frequency limitations on specific podiatric services (e.g.: “Podiatric services pertaining to the cleaning, trimming and cutting of toenails, often referred to as palliative or maintenance care, shall be reimbursed once per 61 day period.”).
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Are there explicit limitations on coverage of routine foot care?”
- States were coded “No explicit limitations on coverage of routine foot care” if the law or program documents stated that routine foot care is a covered service, but did not indicate explicit limitations on coverage.
States were coded “Routine foot care is covered only in instances of medical necessity or in the presence of triggering conditions” if the law or program documents explicitly indicated that routine foot care (or equivalent services under alternate nomenclature such as: “preventive foot care”) is a covered service only in the presence of specific comorbidities or general medical necessity as-defined by state law (e.g.: “ROUTINE FOOT CARE: Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous.”; “The department shall pay for routine foot care only if the client has a systemic condition.”; “The requirement for coverage of routine foot care is that a member must have one of the following diagnoses: Arteriosclerosis obliterans (A.S.O. arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis) Buerger’s disease…”).

States were coded “Routine foot care is not covered in any instance.” in instances where the law or program documents explicitly state that “routine foot care” is a non-covered service, and provide no pathway to coverage in the presence of triggering conditions or medical necessity (e.g.: “MO HealthNet does not cover routine foot care. This involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement or reduction), and other hygienic or preventive maintenance.”).

States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

Question: “Are there explicit limits on the number of routine foot care visits allowable per specified period?”

States were coded “Yes” in instances if the law or program documents outline an explicit limit on the number of routine foot care visits allowable over a specified duration (e.g.: “The department shall pay for routine foot care only if the client has a systemic condition. Services are limited to one treatment every sixty days.”).

States were coded “No” in instances where the law or program documents explicitly stated that there are no limits on the frequency of routine foot care visits.

States were coded “No” in instances if the law or program documents explicitly stated that routine foot care is a covered service, but did not outline frequency limits on the receipt of the service.
States were coded “Routine foot care is not covered in any instance.” in instances where the law or program documents explicitly state that “routine foot care” is a non-covered service, and provide no pathway to coverage in the presence of triggering conditions or medical necessity (e.g.: “MO HealthNet does not cover routine foot care. This involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement or reduction), and other hygienic or preventive maintenance.”).

States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Is prior authorization explicitly required for any podiatric services?”

- States were coded “Yes” if the law or program documents explicitly stated that any podiatric service required prior authorization before it could be reimbursed by Medicaid.
- States were coded “No” if the law or program documents explicitly stated that podiatric services did not require prior authorization before reimbursement by Medicaid.
- States were coded “No” if there was documentation for prior authorization provisions for coverage of other Medicaid services (eg. Dentistry), but none for podiatric services.
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Are out-of-pocket costs indicated for podiatric services?”

- States were coded “Yes” if the law or program documents explicitly stated that there was a copay required for any podiatric service.
- States were coded “No” if the law or program documents explicitly stated that there was no copay required for any podiatric service.
- States were coded “No” if there were documented copay requirements for other Medicaid services (eg. dentistry) but none for podiatric services.
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “Are there podiatric services that are explicitly not covered?”

- States were coded “Yes” if the law or program documents explicitly stated that there were podiatric services that were not covered by Medicaid.
- States were coded “No” if the law or program documents did not explicitly state any podiatric services that were not covered by Medicaid.
States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**Question:** “May podiatric services listed as “non-covered” be covered in instances of medical necessity?”

- States were coded “Yes” if the law or program documents indicated instances where an explicitly non-covered podiatric service will be covered by Medicaid. (e.g. “1. Routine Foot Care services are covered only when: a. The Client or caregiver is not capable of performing routine foot care without risk of injury; and b. The procedure does not duplicate another Provider’s procedure during a 60 day period, which starts from the date of service of the first procedure; and….”)
- States were coded “No” if there was no instance in the law or program documents under which a non-covered podiatric service would be covered.
- States were coded “Data missing. Unable to reach state agencies for clarification” if there was no information available or information was ambiguous in the law or program documents and state agencies did not return contact requests.

**V. Quality Control**

- **Quality Control – Background Research:** Researchers split the task of collecting raw information from each jurisdiction. Full-text of statutes, regulations, program documents, web pages, news articles, and e-mail correspondence were placed on a shared drive in jurisdiction-specific directories.

- **Quality Control – Coding**
  
  i. **Original coding:** Once data collection was complete, each researcher independently coded all 51 jurisdictions.

  ii. **Inter-rater coding (Redundant coding):** Researchers then met and compared their individual coding tables against one another. Any divergences were discussed and, if possible, resolved. If a resolution could not be reached, the case was discussed with both researchers and the principal investigator. If questions still remained, the team would reach out to state officials or others for clarification and additional documentation. The consensus coding was utilized to create a final coding table of 51 entries with resolved divergences.

**Post-production statistical quality control:** This final coding table was subsequently utilized during entry into the final LawAtlas dataset. Two researchers entered 22 and 29 entries respectively into the system. Each
of these final entries was subject to a final comparison against the original primary data source by the researcher uploading the record.

**Final data check:** Prior to publication, the Research Team made a final check of the data on LawAtlas. Any coding final coding errors and discrepancies were discussed and resolved.