Program Memorandum Carriers

Department of Health and Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-02-091 **Date: DECEMBER 27, 2002**

CHANGE REQUEST 2374

SUBJECT: Provider Education Article: Requirements for Payment of Medicare Claims for Foot and Nail Care Services

An article is attached that will assist you in informing the provider community about Medicare's requirements for payment of services for foot and nail care claims.

Include this article in your next regularly scheduled bulletin and post it within two weeks on any web sites or electronic bulletin boards you maintain. You are encouraged to include any additional information in your bulletin to supplement or complement the article.

The effective date for this PM is December 27, 2002.

The implementation date for this PM is December 27,2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded one year after release.

If you have questions, contact the appropriate regional office.

Attachment

Attachment

Requirements for Payment of Medicare Claims for Foot and Nail Care Services

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare nail debridement payments, which is the single largest paid podiatric service. The OIG found that about one in every four claims did not include documentation of medical need for nail debridement in beneficiaries' medical records and that more than half of these inappropriate payments included other related inappropriate payments. This article explains the requirements for payment of Medicare claims for foot and nail services including information about routine foot care exclusion, exceptions to routine foot care exclusion, Class Findings, billing instructions, required claim information, and documentation on file.

Routine Foot Care Exclusion

Except as noted in "Exceptions to Routine Foot Care Exclusion" section, routine foot care is excluded from coverage. Services that are normally considered routine and not covered by Medicare include:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care such as cleaning and soaking the foot, use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

Exceptions to Routine Foot Care Exclusion

- Services performed as a necessary and integral part of otherwise covered services such as diagnosis and treatment of ulcers, wounds, infections, and fractures.
- The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional. Certain procedures that are otherwise considered routine may be covered when systemic condition(s), demonstrated through physical and/or clinical findings, result in severe circulatory embarrassment or areas of diminished sensation in the legs or feet and may pose a hazard if performed by a nonprofessional person on patients with such systemic conditions. In the case of patients with systemic conditions such as diabetes mellitus, chronic thrombophlebitis, and peripheral neuropathies involving the feet associated with malnutrition and vitamin deficiency, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, and uremia, they must also be under the active care of a doctor of medicine or doctor of osteopathy and who documents the condition in the patient's medical record.

- Services performed for diabetic patients with a documented diagnosis of peripheral neuropathy and loss of protective sensation (LOPS) and no other physical and/or clinical findings sufficient to allow a presumption of coverage as noted in the Medicare Carriers Manual. This class of patients can receive an evaluation and treatment of the feet no more often than every six months as long as they have not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidelines. Five sites should be tested on the plantar surface of each foot, according to NIDDK guidelines.

- Treatment of warts, including plantar warts, may be covered. Coverage is to the same extent as services provided for in treatment of warts located elsewhere on the body.

- Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

NOTE: Active care is defined as treatment and/or evaluation of the complicating disease process during the six-month period prior to rendition of the routine care or had come under such care shortly after the services were furnished, usually as a result of a referral.

Class Findings

A presumption of coverage may be made by Medicare where the claim or other evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, the following findings are pertinent:

- **Class A Findings**

  Nontraumatic amputation of foot or integral skeleton portion thereof

- **Class B Findings**

  Absent posterior tibial pulse

Advanced trophic changes; three of the following are required: hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), skin color (rubor or redness)
Absent dorsalis pedis pulse

- **Class C Findings**

  Claudication

  Temperature changes

  Edema

  Paresthesia

  Burning

Billing Instructions

The following are the main HCPCS/CPT codes for billing of foot and nail care services (additional codes can be found in the HCPCS/CPT code book):

11719 – Trimming of nondystrophic nails, any number

11720 – Debridement of nail(s) by any method(s); one to five

11721 – Debridement of nail(s) by any method(s); six or more

11730 – Avulsion of nail plate, partial or complete, simple; single

11732 – Avulsion of nail plate, partial or complete, simple; each additional nail plate (list separately in addition to code for primary procedure)

Required Claim Information

NOTE: Program Memorandums AB-02-096 dated July 17, 2002 and AB-02-109 dated July 31, 2002 contain claim and billing instructions for peripheral neuropathy. For information on completing the CMS-1500 form, see the "Medicare Made Easy" publication (or other carrier-specific guides) at [INSERT WEB SITE ADDRESS]. You may also contact our Customer Service Department at [INSERT TELEPHONE NUMBER]. The following requirements are of particular importance to podiatrists:

Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. A referring physician is a physician who requests an item or service for the patient for which payment may be made under the Medicare program.
Item 17a. Enter the CMS assigned UPIN of the referring/ordering physician listed in item 17.

Item 19. Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 24d. Enter the procedures, services, or supplies using the HCPCS/CPT code. When applicable, show HCPCS modifiers with the HCPCS code. Enter the Q7 – One Class A finding; Q8 – Two Class B findings; or Q9 – One Class B and two Class C findings as appropriate.

Enter the specific procedure code without a narrative description.

Item 24e. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; enter either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses in item 21.

Documentation on File

Podiatrists may submit claims using the Q7, Q8, or Q9 modifiers to indicate to the carriers the findings they have made on the patient's condition. This does not relieve them of the responsibility of maintaining documentation on file. This documentation must be maintained and made available to the carriers at their request. Failure to produce appropriate documentation may result in denial of the claim. Podiatrists should consult their carriers to verify that they are meeting the documentation requirements for Medicare claims.