Medicare
Home Health Agency Manual

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

Transmittal 299 **Date: MARCH 21, 2002**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
232.9 (Cont.) – 232.10	24i – 24j (2 pp.)	24i – 24j (2 pp.)

CLARIFICATION - *EFFECTIVE DATE:* Not Applicable

Section 232.9, Excluded Foot Care Services, clarifies the criteria for foot care policy in subsection C.

Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions, such as osteoarthritis, bursitis (including bunion), tendonitis, etc. that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxated foot structure that 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 induced or associated symptomatic condition, is a covered service.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.--Routine foot care includes the cutting or removal of corns, or calluses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. For example, foot care such as routine soaking and application of topical medication on the physician's order between required visits to the physician is not covered. In addition, any treatment of a fungal (mycotic) infection of the toenail is considered routine and not covered in the absence of (1) clinical evidence of mycosis of the toenail, and (2) compelling medical evidence documenting that the patient either (A) has a marked limitation of ambulation requiring active treatment of the foot, or (B) in the case of a nonambulatory patient has a condition that is likely to result in significant medical complications in the absence of such treatment.

NOTE: Effective July 1, 1981, the treatment of warts (including plantar warts) is no longer considered routine foot care. As a result, services provided for the treatment of warts on the foot are covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

The nonprofessional performance of certain foot care procedures otherwise considered routine, such as cutting or removal of corns, calluses, or nails, can present a hazard to individuals with certain disease processes. If such procedure does present a hazard to the beneficiary, it is not considered routine when he/she is under the care of a doctor of medicine or osteopathy for a metabolic disease, such as diabetes mellitus, or for other conditions that have resulted in circulatory embarrassment or areas of desensitization in the legs or feet.

Services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services; such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

Foot care, that would otherwise be considered routine in the absence of a localized illness, injury or symptoms involving the feet, may be covered if a localized illness, injury or symptoms involving the feet are present (as provided under 42 C.F.R. § 411.15(1)(1)(i)), the person otherwise qualifies for the home health benefit, and the following criteria are met:

- The patient is eligible for the home health benefit.
- The patient’s underlying medical condition creates a need for foot care which is deemed reasonable and necessary.
- The skills of a nurse are indicated to render the service due to the underlying condition of the patient.
- The foot care provided is under the auspice of the skilled nurse’s State Practice Act.

NOTE: The services provided for in the Decision Memorandum on diabetic foot care, http://www.hcfa.gov/coverage/8b3-o2.htm, will soon be published in Section 50-8.1, (Diabetic Peripheral Neuropathy with Loss of Protective Sensation), of the CIM, (Coverage Issues Manual). These services are physicians' services that cannot be delivered under the home health benefit.

232.10 Custodial Care.--Custodial care is excluded from coverage under Medicare.

232.11 Cosmetic Surgery.--Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury, or for the improvement of the functioning of a malformed body member. For example, this inclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

232.12 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.--

A. General.--Payment may not be made under Part A or Part B for expenses which constitute charges by immediate relatives of the beneficiary or by members of his/her household. The intent of this exclusion is to bar Medicare payment for items and services which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s). It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s).

B. Immediate Relative.--The following degrees of relationship are included within the definition of immediate relative:

- husband and wife;
- natural or adoptive parent, child, and sibling;
- stepparent, stepchild, stepbrother, and stepsister;
- father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- grandparent and grandchild; and
- spouse of grandparent and grandchild.

NOTE: A brother-in-law or sister-in-law relationship does not exist between the owner of a provider or supplier and the spouse of his wife's (her husband's) brother or sister.

A father-in-law or mother-in-law relationship does not exist between the owner of a provider and his/her spouse's stepfather or stepmother.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. Thus, for example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider treats the owner's father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative and, therefore, are excluded from coverage.

C. Members of Patient's Household.--These are persons sharing a common abode with the patient as a part of a single family unit, including those