Podiatry Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

A podiatrist is a doctor of podiatric medicine (DPM) who specializes in the diagnosis and treatment of conditions affecting the foot, ankle and related structures. The Massachusetts Board of Registration in Podiatry licenses qualified applicants and establishes rules and regulations to ensure the competence of licensed podiatrists (249 CMR 2.00 through 7.00). DPMs receive education and training comparable to that of a medical doctor including four years of undergraduate education, four years of graduate study in one of nine podiatric schools accredited by the American Podiatric Medical Association, and at least 3 years of post-graduate, hospital-based residency training. Podiatrists can perform surgery, prescribe drugs, and order lab tests or x-rays.

The Plan covers podiatry services that are medically necessary for the treatment of conditions affecting the foot, ankle and related structures. The scope of practice for podiatry is defined by state law. Routine foot care, as defined below, is generally excluded from coverage. However, there are exceptions to this exclusion – see **Exceptions to Routine Foot Care Exclusion** below.

For Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central) members, the Plan covers podiatry services in accordance with National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and applicable Medicare statutes and regulations.

Links:
NCD Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility (70.2)
LCD Routine Foot Care and Debridement of Nails (L33636)
LCA Billing and Coding: Routine Foot Care and Debridement of Nails (A57759)
Medicare Benefit Policy Manual, Chapter 15, Section 290 - Covered Medical and Other Health Services

For NaviCare members, the Plan covers podiatry services in accordance with the National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and applicable Medicare statutes and regulations. Additionally, for NaviCare members, the Plan covers podiatry services in accordance with MassHealth regulations 130 CMR 424.00.

The Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes is outside of the scope of this payment policy. Refer to **NCD Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (70.2.1)** and Medicare Claims Processing Manual, Chapter 32, Section 80 - Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes for additional information. (Note: Routine foot care of a diabetic patient with diabetic sensory neuropathy resulting in LOPS is billed with HCPCS code G0247 and must be billed on the same date of service as either G0245 or G0246 in order to be considered for payment.)

Routine Foot Care
The following services are considered to be components of routine foot care regardless of the provider rendering the service:

- Cutting or removal of corns and calluses;
- Clipping, trimming, or debridement of nails, including debridement of mycotic nails;
- Shaving, paring, cutting or removal of keratoma, tyloma, and heloma;
- Non-definitive simple, palliative treatments like shaving or paring plantar warts which do not require thermal or chemical cautery and curettage;
- 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 either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body. The Plan covers the non-cosmetic removal of benign skin lesions, including warts, when symptoms or signs that warrant medical intervention are present. See **Removal of Benign Skin Lesions** below.

Exceptions to the Routine Foot Care Exclusion
While routine foot care is generally excluded from coverage there are specific exceptions under which routine foot care may be covered:

1. Necessary and Integral Part of Otherwise Covered Services – Services ordinarily considered routine might 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.

2. Presence of Systemic Condition - The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. In these instances, certain foot care procedures that otherwise are considered routine (as previously defined) may pose a hazard when performed by a nonprofessional person.

   Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care:

   - Diabetes mellitus *
   - Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
   - Buerger's disease (thromboangiitis obliterans)
   - Chronic thrombophlebitis *
   - Peripheral neuropathies involving the feet:
     - Associated with malnutrition and vitamin deficiency *
       - Malnutrition (general, pellagra)
       - Alcoholism
       - Malabsorption (celiac disease, tropical sprue)
       - Pernicious anemia
     - Associated with carcinoma *
     - Associated with diabetes mellitus *
     - Associated with drugs and toxins *
     - Associated with multiple sclerosis *
     - Associated with uremia (chronic renal disease) *
     - Associated with traumatic injury
     - Associated with leprosy or neurosyphilis
     - Associated with hereditary disorders
       - Hereditary sensory radicular neuropathy
       - Angiokeratoma corporis diffusum (Fabry's)

- Amyloid neuropathy

When the plan member's systemic condition is one of those designated above by an asterisk (*), and the services are rendered by a podiatrist, routine foot care is covered if the plan member is under the active care of a doctor of medicine or osteopathy (MD or DO) for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the date the routine foot care services are rendered. For conditions designated by an asterisk (*), the Plan will require documentation of the date the member was last seen and the NPI of the MD or DO actively managing the patient's systemic condition. If the plan members condition is one noted with an (*) and the plan member has not been seen by an MD or DO for that condition within the previous six months, routine foot care is not covered.

Presumption of Coverage - When evaluating whether routine foot care can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement.

For purposes of applying this presumption the following physical and clinical findings which are indicative of severe peripheral involvement must be documented and maintained in the member's record in order for routine foot care services to be reimbursable:

Class A Findings
- Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B Findings
- Absent posterior tibial pulse;
- Advanced trophic changes as (three required):
  - hair growth (decrease or absence);
  - nail changes (thickening);
  - pigmentary changes (discoloration);
  - skin texture (thin, shiny) skin color (rubor or redness); and
- Absent dorsalis pedis pulse.

Class C Findings
- Claudication;
- Temperature changes (e.g., cold feet);
- Edema;
- Paresthesias (abnormal spontaneous sensations in the feet); and
- Burning.

The presumption of coverage may be applied when the provider rendering the routine foot care documents (one of the following):
- One (1) Class A finding (submit HCPCS modifier Q7)
- Two (2) Class B findings (submit HCPCS modifier Q8)
- One (1) Class B finding and two (2) Class C findings (submit HCPCS modifier Q9)

Routine foot care may also be covered for plan members with peripheral neuropathy involving the feet, but without the vascular impairment outlined in Class B findings. The neuropathy should be of such severity that care by a non-professional person would put the plan member at risk. If the plan member has evidence of neuropathy but no vascular impairment, the use of class findings modifiers is not necessary.

3. Mycotic nails – Treatment of mycotic nails may be covered under the Exceptions to the Routine Foot care Exclusion when one of the following situations is present:

   a. A systemic condition with adequate documentation of class findings as outlined above, indicating the presence of qualifying systemic illnesses causing a peripheral neuropathy. Payment may be made for the debridement of a mycotic nail (whether by manual method or by electrical grinder) when definitive antifungal treatment options have been reviewed

and discussed with the patient at the initial visit and the physician attending the mycotic condition documents that the criteria are met.

b. In the absence of a systemic condition, treatment of mycotic nails may be covered when one of the following criteria are met:
   i. For an ambulatory plan member (1) there is clinical evidence of mycosis of the toenail, and (2) the plan member has marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.
   ii. For a non-ambulatory plan member: (1) there is clinical evidence of mycosis of the toenail, and (2) the plan member suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

4. In addition, procedures for treating toenails are covered for the following:
   a. Onychogryphosis (defined as long-standing thickening, in which typically a curved hooked nail [ram's horn nail] occurs), and there is marked limitation of ambulation, pain, and/or secondary infection where the nail plate is causing symptomatic indentation of or minor laceration of the affected distal toe; and/or
   b. Onychauxis (defined as a thickening [hypertrophy] of the base of the nail/nail bed) and there is marked limitation of ambulation, pain, and/or secondary infection that causes symptoms.

Limitations

1. Covered Exceptions to Routine Foot Care Exclusion are considered medically necessary once (1) in 60 days. More frequent services will be denied as not reasonable and necessary.
2. The exclusion of foot care is determined by the nature of the service, regardless of the clinician who performs the service.
3. Medicare allows payment for routine foot care only if the conditions under indications are met. These conditions describe the systemic diseases and their peripheral complications that increase the danger for infection and injury if a non-professional provides these services.
4. Services not meeting the criteria in this statement of national coverage will be denied as statutory non-covered services. For diagnosis codes designated by an asterisk (*), we will require the date the patient was last seen (DPLS) and the NPI of the Doctor of Medicine or Doctor of Osteopathic Medicine (MD or DO) actively managing the patient's systemic condition.
5. Nail debridement procedures are considered non-covered routine foot care when these services do not meet the guidelines outlined above for mycotic nail services or are not based on the presence of a systemic condition. If the nail debridement procedures are performed in the absence of mycotic nails and as part of foot care, they must meet the same criteria as all other routine foot care services to be considered for payment.
6. Foot care services that do not require a professional would be considered routine and not a Medicare benefit. Professional in this situation is defined as an M.D., D.O., D.P.M., Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant.
7. Effective for dates of service on or after December 1, 2023, a Registered Nurse that holds foot care certification such as Certified Foot Care Nurse (CFCN) or Certified Foot Care Specialist (CFCS) or other similar certifications or independent training by supervising professionals may perform covered foot care services for Medicare (Medicare Advantage, NaviCare and PACE) and Community Care members when all the following requirements are met:
   a. Services are performed under direct supervision of a physician or qualified nonphysician practitioner.
   a. All requirements of the "incident to" provision are met per the Medicare Benefit Policy Manual (Chapter 15, Section 60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service).
   b. Proof of certification must be available to the Plan upon request.
   c. All other coverage provisions outlined in this payment policy are met.

References:
Medicare Benefit Policy Manual, Chapter 15, Section 290 - Covered Medical and Other Health Services.
MLN Matters Number: SE1113, Foot Care Coverage Guidelines.
National Government Services Local Coverage Determination (LCD) for Routine Foot Care and Debridement of Nails (L33636), Revision Effective Date: For services performed on or after 08/18/2022.
National Government Services Billing and Coding Article: Routine Foot Care and Debridement of Nails (A57759) Revision Effective Date 01/01/2024.

Removal of benign skin lesions (warts)
The Plan does not cover cosmetic surgery or expenses incurred in connection with such surgery.

The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body. The Plan covers the non-cosmetic removal of benign skin lesions, including warts, when symptoms or signs that warrant medical intervention are present.

The following are examples of benign skin lesions:
- Sebaceous (epidermoid) cysts
- Skin tags
- Milia (keratin-filled cysts)
- Nevi (moles)
- Acquired hyperkeratosis (keratoderma)
- Papillomas
- Hemangiomas
- Viral warts

Removal of benign skin lesions is not considered cosmetic when symptoms or signs which warrant medical intervention are present, including but not limited to:
- Bleeding
- Intense itching
- Pain
- Change in physical appearance, for example, but not limited to:
    - Reddening
    - Pigmentary change
    - Enlargement
    - Increase in the number of lesions
- Physical evidence of inflammation or infection, e.g., purulence, oozing, edema, erythema, etc.
- Lesion obstructs an orifice
- Lesion clinical restricts eye function, for example, but not limited to:
    - Lesion restricts eyelid function
    - Lesion causes misdirection of eyelashes or eyelid
    - Lesion restricts lacrimal puncta and interferes with tear flow
    - Lesion touches globe
- Clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesion appearance
- Wart removal is not considered cosmetic when guidelines above are met, or if any of the following clinical circumstances are present:
    - Periocular warts associated with chronic recurrent conjunctivitis thought to be secondary to lesion virus shedding
    - Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients or warts of recent origin in immunocompromised patients
    - Lesions are condyloma acuminata or molluscum contagiosum
    - Cervical dysplasia or pregnancy is associated with genital warts

Reference:
National Government Services, Inc. Billing and Coding Article: Removal of Benign Skin Lesions (A54602), Revision Effective Date 01/01/2024.

Reimbursement

The Plan will reimburse contracted podiatrists for covered services. The scope of the practice for podiatry is defined by state law; therefore, individual state laws should be followed in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.

Note: The policies and codes for routine foot care are not used exclusively by podiatrists. These codes may be used to report routine foot care services regardless of the specialty of the physician who furnishes the services.

The Plan will use appropriate industry guidance for specific CPT/HCPCS and ICD-10 billing combinations. Failure to appropriately bill with the most specific and appropriate coding may result in the denial of a claim.

Effective for dates of service on or after March 1, 2024, the Plan will align with the National Government Services LCD for Routine Foot Care and Debridement of Nails (L33636) with respect to the ICD-10-CM diagnosis codes that will support medical necessity for routine foot care.

The Plan will not pay for an evaluation and Management (E & M) service on the same day as routine foot care or a minor surgical procedure unless a documented significant and separately identifiable medical service is rendered. The significant, separately identifiable E & M service must be fully and clearly documented in the plan member's medical record and a modifier 25 should be appended to the E & M code.

Referral/notification/prior authorization requirements

A PCP referral is required for most podiatry services.

While routine foot care is generally excluded from coverage there are specific exceptions under which routine foot care may be covered. A PCP referral is not required for foot care that would otherwise be considered routine but for the presence of an Exception to the Routine Foot Care Exclusion.

Some podiatry procedures, including podiatric surgery, require prior authorization. Providers can use the Procedure Code Look-up tool on the Plan website to find out if prior authorization is required for a specific CPT or HCPCS code.

Podiatry services, including routine foot care rendered in a long term care or skilled nursing facility require prior authorization.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Billing/coding guidelines

The Plan requires podiatry services claims to be submitted with the most specific ICD-10-CM diagnosis code(s) for the procedure code utilized.

For services requiring a PCP referral for, the name and NPI of the PCP must be reported in Item 17 and 17B of the CMS-1500 or equivalent electronic claim format.

For services requiring a PCP referral for Medicare Advantage and NaviCare members, there must be a ProAuth PCP referral on file at Fallon Health.

For services requiring a prior authorization for all members, an approved prior authorization must be on file with Fallon Health.

The Plan will utilize correct coding guidance from CMS in addition to other industry standard resources.

The list of codes is provided for reference only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Inclusion of a code does not imply reimbursement or guarantee claim payment.

Claims for routine foot care and removal of benign skin lesions performed merely for cosmetic reasons do not need to be submitted to the Plan unless the member requests that a formal denial. If a claim is filed, ICD-10-CM code Z41.1 (Plastic surgery for unacceptable cosmetic appearance) should be used in conjunction with the appropriate CPT code.

NCCI has procedure-to-procedure (PTP) edits that deny certain code combinations as mutually exclusive. Under certain circumstances, the podiatrist may want to indicate that a procedure was distinct from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under certain circumstances. Modifiers XE, XS, XP, XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. Modifier 59 should only be used if there is no other, more appropriate modifier to describe the relationship between the two procedure codes.

Claims submitted for mutually exclusive routine foot care services with modifier 59 (or XE, XS, XP, XU as appropriate) will deny upon initial submission. A Provider Appeal must be submitted with supporting medical records for payment consideration.

For MassHealth ACO members, payment for the removal of an ulcerated keratosis is included in the fee for any type of visit and must not be billed separately. CPT codes 11420-11423, 11424-11426, 17000-17003 and 17004 will deny if billed with diagnosis L57.0 (Actinic keratosis) and 99202-99204 or 99211-99214.

CPT/HCPCS codes for Routine Foot Care
Effective for dates of service on or after March 1, 2024, the Plan will align with National Government Services, Inc. LCD for Routine Foot Care and Debridement of Nails (L33636) with respect to the ICD-10-CM diagnosis codes that will support medical necessity for routine foot care.

When coverage for routine foot care is based on the presence of a qualifying systemic condition, one of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, 11720 and 11721:

- Modifier Q7: One (1) Class A finding
- Modifier Q8: Two (2) Class B findings
- Modifier Q9: One (1) Class B finding and two (2) Class C findings

The ICD-10-CM codes that support medical necessity are listed in Group 1 in the National Government Services Billing and Coding Article for Routine Foot Care and Debridement of Nails (A57759) (Revision Effective Date 01/01/2024). When the member's condition is one of those designated by an asterisk (*),routine foot care is covered only if the plan member is under the active care of a doctor of medicine or osteopathy (MD or DO) for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the date the routine foot care services are rendered.

Treatment of mycotic nails, or onychogryphosis, or onychauxis (codes 11719, 11720, 11721 and G0127), may be covered under the Exceptions to the Routine Foot Care Exclusion when the member has a qualifying systemic condition. Class findings must be documented and reported with the appropriate modifiers (Q7, Q8, or Q9) as listed above. If the member has evidence of

neuropathy, but no vascular impairment, class findings modifiers are not required, ICD-10-CM diagnosis code B35.1, L60.2 or L60.3, must be reported as the primary diagnosis code, with the diagnosis representing the member's symptom reported as the secondary diagnosis code. Secondary diagnoses that may be reported with B35.1, L60.2 or L60.3 for treatment of mycotic nails, onychogryphosis, and onychauxis to indicate medical necessity are listed in Group 3 in the National Government Services Billing and Coding for Routine Foot Care and Debridement of Nails (A57759) (Revision Effective Date 01/01/2024).

Coverage for routine foot care is also available for members with peripheral neuropathy involving the feet, but without vascular impairment. Because the member has evidence of neuropathy but no vascular impairment, the use of class findings modifiers is not necessary. The ICD-10-CM diagnosis codes that support medical necessity are listed in Group 4 in the National Government Services Billing and Coding for Routine Foot Care and Debridement of Nails (A57759) (Revision Effective Date 01/01/2024). When the member's condition is one of those designated by an asterisk (*),routine foot care is covered only if the plan member is under the active care of a doctor of medicine or osteopathy (MD or DO) for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the date the routine foot care services are rendered.

Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127 should be billed with a unit of "1" regardless of the number of lesions or nails treated.

Code	Description
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method(s); 1 to 5
11721	Debridement of nail(s) by any method(s); 6 or more
G0127	Trimming of dystrophic nails, any number

CPT/HCPCs codes for other podiatry procedures

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)
11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)
11760	Repair of nail bed
11765	Wedge excision of skin of nail fold (eg, for ingrown toenail)

CPT/HCPCS codes for removal of benign lesions (warts)

The procedure for destruction of benign lesion (wart) is billed as CPT 17110. CPT code 17110 should be reported with one unit of service for the destruction of up to 14 benign lesions (warts). CPT code 17111 is reported with one unit of service for destruction of 15 or more benign lesions (warts).

One of the following ICD-10-CM diagnosis codes should be billed based on the clinical indications of the lesion:

- B07.0 (Plantar wart)
- B07.8 (Other viral warts)
- B07.9 (Viral wart, unspecified)

Medical records maintained by the provider must clearly document the medical necessity for the wart removal(s).

Code	Description
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

Place of service

This policy applies to services rendered in any place of service.

Policy history

Origination date:	12/01/2019
Connection date & details:	October 2019 –Introduced as a new policy. April 2020 – Updated Referral/notification/prior authorization requirements. October 2020 – Clarified coverage and billing requirements for routine foot care. January 2022- Added Removal of Benign Skin Lesions to Policy section; clarified billing requirements for ulcerated keratosis for MassHealth ACO members. January 2024 – Under Policy, added links to applicable Medicare guidance, also under Policy, updated Limitations; under Reimbursement, added that effective for dates of service on or after March 1, 2024, the Plan will align with the National Government Services, Inc. LCD for Routine Foot Care and Debridement of Nails (L33636) with respect to the ICD-10-CM diagnosis codes that will support medical necessity for routine foot care; under Billing/coding guidelines, clarified requirements for billing and coding of routine foot care and removal of benign lesions (warts).

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply, and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.