



Foot Care Questions and Answers

Billing and Coding

1) What are the coverage guidelines for treatment of mycotic nails?

The treatment of mycotic nails (11720 or 11721) would fall under either the routine foot care guidelines in which case the patient must meet the criteria for the systemic conditions or Q modifier guidelines. Or the treatment may be covered if the patient meets the guidelines in the policy for mycotic nail guidelines. The documentation should show why the physician or nonphysician practitioner is providing the service.

2) I am performing debridement of 6 mycotic nails. Do I bill 11720 with 1 number of service and 11721 with one number of service?

The CPT descriptor of the code provides the indication of how many services to bill. CPT code 11720 is intended to be reported for the debridement of 1-5 nails. CPT code 11721 is intended to be reported for the debridement of 6 or more nails. In either situation, you would bill only one unit of service. For more information please refer to CPT Assistant.

3) What is the effective date that podiatrists are allowed to be the ordering/referring provider for MRI and CT diagnostic tests?

Effective January 1, 2005, podiatrists may order/refer for MRI and CT diagnostic tests 73700-73725, 76375, and 76380.

Policy and Coverage

1) How often will Medicare pay for nail trimming?

Generally, Medicare will cover this service up to once every 60 days, if the beneficiary's condition meets all the necessary requirements.

In rare circumstances, Medicare may approve visits that are more frequent if the provider submits the claim with documentation describing the medical circumstance relating to the patient's condition explaining the need for more frequent or extra visits.

2) Are routine foot care services ever covered by Medicare?

Yes, foot care services that are normally considered routine may be covered under two circumstances:

- When the beneficiary has a systemic condition, which results in severe circulatory problems, where foot or nail care procedures performed by a non-professional may be detrimental to the health of the beneficiary.
- When there is clinical evidence of mycosis of the nails and the beneficiary's symptoms include ambulation limitations, pain, or secondary infection resulting from the mycotic infection.

3) In order for a routine service to be covered, what information about the beneficiary's condition is required to show medical necessity?



- A diagnosis reporting the systemic condition.
- Physical and/or clinical findings consistent with the diagnosis and indicating severe peripheral involvement.
- The following findings are pertinent and should be documented in the patient's medical record:

Class A Findings:

Nontraumatic amputation of foot or integral skeletal portion

Class B Findings:

- Absent posterior tibial pulse
- Advanced trophic changes (three required): hair growth (decrease or absence);
- Nail changes (thickening); pigmentary changes (discoloration); skin texture (thin, shiny); skin color (rubor or redness)
- Absent dorsalis pedal pulse

Class C Findings:

- Claudication
- Temperature changes (e.g. cold feet)
- Edema
- Parasthesia (abnormal spontaneous sensations in the feet)
- Burning

Services may be covered when the provider has identified:

- One Class A finding or
- Two Class B findings or
- One Class B and two Class C findings

4) Is it necessary for a beneficiary to be under the care of a doctor for routine procedures to be covered?

For certain systemic conditions, routine procedures are covered only if the patient is under the active care of a doctor of medicine (M.D.) or osteopathy (D.O.) who documents the condition.

An M.D. or D.O. must see the beneficiary to treat and/or evaluate the disease during the 6-month period before the routine type service or shortly after the services were furnished.

These conditions are designated by an asterisk (*) in the list in question 3 under the "Definitions and Examples" Q&A category.

Mere statement of a diagnosis does not indicate the severity of the condition.

5) Which types of providers may provide foot care to Medicare beneficiaries?

Any provider, including podiatrists and primary care doctors, may perform foot care services, if the care is within the scope of the provider's practice, as defined by law. Medicare will make the decision whether to cover the services based on the beneficiary's diagnosis.

Modifiers

**1) When is it appropriate to apply the T Modifier when providing foot care services?**

Providers use the T modifiers to identify specific toes. Certain procedure codes require this information. Nail Avulsion, procedure codes 11730 or 11732, is an example. Procedure code 11730 would show one number of service and the T modifier. Procedure code 11732 could show multiple numbers of services depending on the total number of toes involved. Providers can place up to four modifiers on the line of service. Providers would place additional modifiers if need in the narrative field. Other procedure codes do not require the identification of the specific toes on the claim. The information on the specific toes treated would be contained in the office records. Nail Debridement codes 11720 and 11721 fall into this category.

2) When is it appropriate to apply the Q modifiers when providing routine foot/nail care?

Providers use the Q modifiers to identify covered foot care services. The procedure codes include G0127, 11055, 11056, 11057, 11719, 11720, and 11721. The findings documented in the office records will determine if the Q modifier is appropriate and which specific modifier to use. The modifiers are: Q7, one class A finding; Q8, two class B findings; or Q9, one class B and two Class C findings.

Definitions and Examples

1) How does Medicare define debridement?

Medicare defines debridement as "a surgical procedure performed to remove all of the abnormal and/or diseased nail body/plate and debris of the infected nail bed."

Reduction of the length or partial thickness of the nail body/plate should not be reported using the debridement Current Procedural Terminology (CPT) codes. Debridement may be performed by manual, mechanical, or chemical means.

2) What kinds of services does Medicare consider routine foot care?

Services considered routine foot care include –

- The cutting or removal of corns or calluses
- The trimming, cutting, or clipping of nails
- The debridement of nails
- Cleaning and soaking the feet
- The use of creams to maintain skin tone of ambulatory and non-ambulatory patients
- Any service performed when there is not a localized illness, injury or symptom involving the feet

3) What are examples of systemic disease?

Systemic Conditions

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases 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*



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- 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
- Long term oral anticoagulant therapy (e.g. Coumadin, Dicoumaral, etc.)

When the patient's condition is one of those designated by an asterisk (), routine foot care services performed by a podiatrist are considered medically reasonable and necessary if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition and that the patient has been seen by that M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the 6-month period prior to the rendition of the routine-type service or had come under such care shortly after the services were furnished.

Advance Beneficiary Notice (ABN)

1) Under what circumstances should I ask the beneficiary to sign an Advance Beneficiary Notice (ABN) prior to the service?

An Advance Beneficiary Notice (ABN) is a written notice informing the beneficiary that you believe Medicare will probably not pay for the services and that they will be financially responsible for the charges. You should ask the beneficiary to sign an ABN each time they request a service, which you expect Medicare to deny. You may access an ABN at:

<http://www.cms.hhs.gov/CMSForms/CMSForms/> on the CMS Website.