Part B Insider (Multispecialty) Coding Alert

Reimbursement: Pocket This Primer on Medicare's Rules for Foot Care

Reminder: Review CMS' guidance on systemic conditions.

Aging beneficiaries may frequent your practice with a plethora of foot-related issues. However, Medicare's policies on routine foot care are confusing and nuanced, and that's why it's essential that you review the rules to ensure you're submitting clean claims.

Background: During the recent Virtual HEALTHCON session "Let's Talk About Feet," speaker **Christopher Chandler, MHA, MBA, CPC, CGSC**, technical manager of documentation and coding for Intermountain Healthcare, discussed how to handle routine foot care in your practice.

Review this primer on the intersection of Medicare and routine foot care policy to help with your claims processes.

Understand Medicare's Routine Foot Care Policy

The Centers for Medicare & Medicaid Services (CMS) does not cover routine foot care unless you meet certain situations or exceptions, Chandler said. Explaining it this way helps providers understand the importance of good documentation and good diagnosis coding if they know that these services are not covered, except in specific situations, he said.

Other payers: When it comes to different payers and their policies for routine foot care, UnitedHealthcare in most areas of the country has adopted Medicare's routine foot care policies, according to Chandler. You should individually check with smaller commercial payers for their policies.

Unless payers have a specific policy in place for something, they'll usually default to Medicare's policy on things, Chandler added. "There are exceptions out there," he said. "You'll have to check with your more common payers and find out what they do. But it's a safe assumption that if they don't have their own policy, they're probably adhering to Medicare's policy."

The following services are considered routine by Medicare:

- The cutting or removal of corns and calluses - codes 11055 (Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion)-11057 (... more than 4 lesions)
- The trimming, cutting, clipping of nails - code 11719 (Trimming of nondystrophic nails, any number)
- The debridement of nails - codes 11720 (Debridement of nail(s) by any method(s); 1 to 5) and 11721 (... 6 or more)
- G0127 (Trimming of dystrophic nails, any number)
- Other hygienic and preventive maintenance care, which includes cleaning and soaking the feet, using skin creams to maintain skin tone of either ambulatory or bedridden patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot

Systemic Conditions Fall Under Exception

An exception to Medicare's routine foot care policy occurs when a patient has a systemic condition like a metabolic, neurologic, or peripheral vascular disease. Medicare identifies some specific systemic conditions that might justify coverage in the Benefit Policy Manual. Note, this is not a comprehensive list:

- Diabetes mellitus*
- Arteriosclerosis obliterans*
- Chronic thrombophlebitis*
- Peripheral neuropathies involving the feet
    - Associated with malnutrition and vitamin deficiency*
    - Associated with diabetes mellitus*
    - Associated with traumatic injury
    - Associated with hereditary disorders

"Systemic" means it affects the entire body, rather than just a single organ or body part, Chandler explained. Therefore, systemic conditions that might justify coverage are not going to be limited to just the foot. It's a condition that affects the entire body, including the foot.

Also, just because the systemic condition is not in Chapter 15 of the Benefit Policy Manual doesn't mean the condition isn't covered, he added. If it's a systemic condition, it may justify coverage, Chandler said.

"You may have a bit of a fight if the condition is not on that list and Medicare would be in their right to deny it because they never guaranteed the systemic condition would justify coverage," he said. "They just said it 'might.'"

However, it's probably worth the fight, especially for the patient who should be going to a podiatrist or MD to have these routine foot care services performed, according to Chandler. Because if the patient has one of these conditions, it's probably too dangerous for the services to be done by someone who is not a doctor.

Diabetes, peripheral neuropathy involving the feet associated with diabetes, and peripheral vascular diseases are the three big ones that are often seen, Chandler added.

Don't miss: Some of the conditions on the systemic conditions list have an asterisk next to them. This means that the "routine services are covered only if the patient is under active care of a MD or DO who documents the condition," Chandler explained. So, a doctor of podiatric medicine (DPM) does not meet this qualification.

Some Medicare Administrative Contractors (MACs) define this qualification as the MD or DO has to have seen the patient within the last six months, according to Chandler. However, some MACs do not give this definition, so you should check with your local MAC and see what their definition is, he suggested.

Documentation tip: "One of the things we recommend to our providers is to make sure they are documenting in their note and covering the bases of whether or not this patient has been seen for the condition by their MD or DO within the last six months," Chandler said.

Class A Findings:

- Nontraumatic amputation of the foot or integral skeletal portion thereof

Class B Findings:

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- Advanced trophic changes as evidenced by any three of the following:
    - Hair growth (decrease or absence)
    - Nail changes (thickening)
    - Pigmentary changes (discoloration)
    - Skin texture (thin, shiny)
    - Skin color (rubor or redness)

Class C Findings:

- Claudication
- Temperature changes
- Edema
- Paresthesias
- Burning

This presumption of coverage can be applied when the podiatrist rendering the routine foot care has identified the following:

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

With the class findings, some MACs require using a Q modifier for each qualifying CPT® code, says **Jeri L Jordan, CPC**, billing manager at Hampton Roads Foot and Ankle in Williamsburg, Virginia.

The Q modifiers are as follows:

- Q7 (One class a finding)
- Q8 (Two class b findings)
- Q9 (One class b and two class c findings)

"Also, to cover routine foot care with the class findings, the patient must wait 61 days between visits," Jordan adds.

Don't miss: When it comes to the absent pulse, "absent" means you cannot feel it at all. It doesn't mean diminished, Chandler cautioned. "Diminished" is a word used a lot by physicians when trying to describe the pulse strength in those locations. However, since "diminished" is not absent, if they say "diminished," this will not meet the requirement.