Podiatry Payment Policy

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 **Conditions that Might Justify Coverage of Routine Foot Care** below.

For NaviCare, the Plan covers podiatry services in accordance with MassHealth regulations 130 CMR 424.00.

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.

Conditions that Might Justify Coverage of Routine Foot Care
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

See National Government Services Local Coverage Article for Routine Foot Care and Debridement of Nails (L33636) for a comprehensive list of covered ICD-10-CM diagnosis codes.

When the plan member's 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 physician or qualified non-physician practitioner ("attending physician") for the treatment and/or evaluation of the condition during the six (6) month period prior to the date the routine foot care services are rendered. The claim and the medical record should include documentation to support this requirement. If the plan members condition is one noted with an (*) and the plan member has not been seen by a physician or qualified non-physician practitioner for that condition within the previous six months, routine foot care would be considered non-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):
- 1 Class A finding (submit HCPCS modifier Q7)
- 2 Class B findings (submit HCPCS modifier Q8)
- Class B and 2 Class C findings (submit HCPCS modifier Q9)

Routine foot care may be covered when 'class findings' related to one or more of the preceding diagnoses are documented and the appropriate HCPCS modifier (Q7, Q8 or Q9) is submitted.

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. Class findings, as outlined above, or the presence of a qualifying systemic illness causing peripheral neuropathy must be present.

4. In the absence of a systemic condition, treatment of mycotic nails may be covered when definitive antifungal treatment options have been reviewed and discussed with the plan member at the initial visit and the attending physician or non-physician practitioner documents that the following conditions are met:
    a. 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.
    b. 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 services are considered medically necessary once (1) in 60 days.

References:
Medicare Benefit 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), Effective for Services Performed on or after 12/26/2019.
National Government Services Local Coverage Article Billing and Coding: Routine Foot Care and Debridement of Nails (A57759) Revision Effective Date 10/1/2021.

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

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.
- 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.

The Plan will not pay for a separate E & M service on the same day as a minor surgical procedure unless a documented significant and separately identifiable medical service is rendered. The service must be fully and clearly documented in the plan member's medical record and a modifier 25 should be used.

References:
National Government Services, Inc. Local Coverage Article Billing and Coding: Removal of Benign Skin Lesions (A54602), Revision Effective Date 05/07/2020.

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.

Referral/notification/prior authorization requirements

A PCP referral is required for podiatry services. Some podiatry procedures 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.

For NaviCare, a PCP referral is required for most podiatry services. Some podiatry procedures require prior authorization including those rendered in a nursing home or for podiatric surgery.

Fallon Health Weinberg Managed Long Term Care (MLTC) and PACE programs are based on member care coordination; therefore, we encourage referring providers to contact the member's designated care team if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

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

For services requiring a referral for Commercial Plan members, 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 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.

An E&M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E&M service is a significant separately identifiable service, indicated by the use of modifier 25, and documented by medical records.

One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, 11720 and 11721 when coverage is based on the presence of a qualifying systemic condition except when the plan member has evidence of neuropathy but no vascular impairment, for which class findings modifiers are not necessary:

- 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

Refer to **National Government Services Local Coverage Article for Routine Foot Care and Debridement of Nails (L33636)** Group 4 Codes for diagnoses that support medical necessity

when the plan member has evidence of neuropathy but no vascular impairment for which class findings modifiers are not required.

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.

"Attending Physician" - When the patient's condition is one of those designated by an asterisk (*), and the services are rendered by a podiatrist, routine foot care procedures are covered if the plan member is under the active care of a physician or non-physician practitioner (attending physician) who documents the condition. The name and National Provider Identifier (NPI) of the attending physician should be reported in Item 19 of the CMS-1500 or the equivalent electronic claim format. The date the patient was last seen by the attending physician must be reported in an eight-digit (MM/DD/YYYY) format in Item 19 of the CMS-1500 claim form or the electronic equivalent.

NCCI has procedure-to-procedure 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.

Code	Description
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
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
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm

11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
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
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)
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)the units equal to lesions from 2 through 14
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)the units equal to lesions greater than 15
G0127	Trimming of dystrophic nails, any number

Place of service

This policy applies to services rendered in outpatient settings.

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.

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.