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Foot Care Coverage Guidelines

Provider Types Affected

This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services

The scope of the practice for Podiatry is defined by state law and the individual state laws should be consulted in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.

This article covers routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare Covered Foot Care Services

According to the "Medicare Benefit Policy Manual" (MBPM), Chapter 15, Section 290, Medicare covered foot care services only include medically necessary and reasonable foot care.

Exclusions from Coverage

Certain foot care related services are not generally covered by Medicare. In general, the following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare:**

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1. Treatment of Flat Foot

The term “flat foot” is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.

2. Routine Foot Care

Except as discussed below in the section entitled “**Conditions that Might Justify Coverage**”, routine foot care is excluded from coverage. Services that normally are considered routine and not covered by Medicare include the following:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance 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.

3. Supportive Devices for Feet

Orthopedic shoes and other supportive devices for the feet generally are not covered, except Medicare does cover such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, a narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

Conditions that Might Justify Coverage

The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) 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 (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a nonprofessional person on patients with such systemic conditions.

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 *

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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

When the patient's condition is one of those designated above by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

In addition, the following may be covered:

- 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.
- In the absence of a systemic condition, treatment of mycotic nails may be covered. **The treatment of mycotic nails for an ambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. **The treatment of mycotic nails for a non ambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Presumption of Coverage for Routine Services

When evaluating whether the routine services 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 the purposes of applying this presumption, please refer to the "Medicare Benefit Policy Manual", Chapter 15, Section 290.

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When the routine services are **rendered by a podiatrist**, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease

Diabetic Sensory Neuropathy: Loss of Protective Sensation (LOPS)

Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Please refer to the "National Coverage Determination (NCD), entitled "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS) (aka Diabetic Peripheral Neuropathy)" for more information. This NCD is available at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=171&ncdver=1&bc=BAAAgAAAAA&> on the Centers for Medicare & Medicaid Services (CMS) website.

Lower Extremity Wound Care

Electrostimulation and Electromagnetic Therapy for Wounds (Claims submitted on or after July 6, 2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical stimulation and electromagnetic therapy for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers when certain conditions are met

For more detailed information, please refer to National Coverage Determination (NCD) for "Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds," which can be found at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=131&ncdver=3&bc=BAABAAAAA> on the CMS website.

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;

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- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy **only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy** and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the NCD for Hyperbaric Oxygen Therapy, which is available at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=12&ncdver=3&NCAId=37&ver=7&NcaName=Hyperbaric+Oxygen+Therapy+for+Hypoxic+Wounds+and+Diabetic+Wounds+of+the+Lower+Extremities&fromdb=true&IsPopUp=y&bc=AAAAAAAAEAgA&>.

Additional Billing Guidelines

Claims Involving Complicating Conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, **the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim**, along with the **approximate date** that the beneficiary was last seen by the indicated physician.
- Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.
- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only non-covered care.
- The exclusion of foot care is **determined by the nature of the service** and not according to who provides the service. When an itemized bill shows both covered services and non-covered services that are not integrally related to the covered service, the portion of the charges that are attributable to the non-covered services should be denied.
- Sometimes payment is made for incidental non-covered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.

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- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is “incident to” a covered procedure.
- Information about coverage **Incident to Physician’s Professional Services** can also be found in the “Medicare Benefit Policy Manual,” Chapter 15, Covered Medical and Other Health Services, Section 60 – Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.
- These diabetic shoes are covered if the requirements specified in the “Medicare Benefits Policy Manual,” Chapter 15, Section 140, regarding certification and prescription are met.
- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, , even if only one foot suffers from diabetic foot disease.
- Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Therapeutic shoes for diabetics are not DME and are not considered DME or orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

The “Medicare Benefit Policy Manual,” Publication 100-2, Chapter 15, can be found at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website.

The “Medicare Program Integrity Manual” can be found at <http://www.cms.gov/manuals/downloads/pim83c05.pdf> on the CMS website.

The “National Coverage Determination Manual” can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html> on the CMS website.

Local Coverage Decisions

The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found at http://www.cms.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P on the CMS website.

Related Change Requests and MLN Matters Articles

Program Memorandum Transmittal AB-02-096, Change Request 2269, “Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People

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with Diabetes” can be found at <http://www.cms.gov/Transmittals/downloads/AB02096.pdf> on the CMS website.

Program Memorandum Transmittal AB-02-105, Change request 2272, “Medical Review of Medicare Payments for Nail Debridement Services,” can be found at <http://www.cms.gov/Transmittals/Downloads/AB02105.pdf> on the CMS website.

MLN Matters article, MM3430, “Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses” can be found at <http://www.cms.gov/MLNMattersArticles/downloads/MM3430.pdf> on the CMS website.

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