UnitedHealthcare®

Reimbursement Policy

Podiatry

Policy Number	POD06012009SC	**Approved By**	UnitedHealthcare Medicare Reimbursement Policy Committee	**Current Approval Date**	09/11/2013

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Summary

Overview

Routine foot care is normally excluded from Medicare coverage except for the following conditions or situations:

1. Necessary and integral part of otherwise covered services
   - **a.** diagnosis and treatment of ulcers, wounds or infections
   - **b.** trimming or cutting nails to be fitted with a cast following a fracture (if the cast is a separately billable service)
2. Presence of systemic conditions
   - **a.** metabolic, neurologic or vascular conditions that may require scrupulous foot care by a professional
3. Treatment of warts on foot
   - **a.** treatment of warts, including plantar warts, on the foot is covered to the same extent as services provided for treatment of warts located elsewhere on the body
4. Mycotic Nails
   - **a.** in the absence of a systemic condition, treatment of mycotic nails may be covered, only when the following criteria are met:
     - Ambulatory patient
     - Clinical evidence of mycosis of the toenail AND
     - Patient has marked limitation of ambulation, pain or secondary infection resulting from thickening and dystrophy of the infected toenail plate
     - Non-ambulatory patient
     - Clinical evidence of mycosis of the toenail AND
     - Patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate

Reimbursement Guidelines

Only certain individual and/or group plans provide benefits for Non-Medicare covered foot care. The line item coding criteria directs a foot care service line to the proper service code using a complex set of criteria including CPT/HCPCS codes, ICD-9-CM codes, and modifiers when applicable. Codes and policies for routine foot care and supportive devices for the feet are not exclusively for the use of Podiatrists. These codes must be used to report foot care services regardless of the specialty of the physician who furnishes the

services. Physicians should use the most appropriate code available when billing for routine foot care.

Relatively few claims for routine-type care are anticipated considering the severity of conditions contemplated as the basis for this exception. Claims for this type of foot care should not be paid in the absence of convincing evidence that nonprofessional performance of the service would have been hazardous for the beneficiary because of an underlying systemic disease. The mere statement of a diagnosis such as those mentioned above does not of itself indicate severity of the condition. Where development is indicated to verify diagnosis and/or severity, records may be requested to review the history and medical conditions of the patient as well as any physician contacts for management of those conditions.

"Q" Modifiers (Q7, Q8, and Q9) are utilized to denote Class A (Q7), Class B (Q8) and Class C (Q9) findings. These modifiers may be used with procedure codes 11055, 11056, 11057, 11719 or G0127 and should be entered in Item 24d of the claim form or the respective field on the electronic 837P.

Submitting claims using Q7, Q8, or Q9 modifiers indicates the findings related to the patient's condition. However, the provider is still responsible for documenting the findings in the patient's record. Failure to provide documentation supporting the use of the Q modifiers on any claim may result in denial of that claim.

Hyperkeratotic Lesions Coding Criteria

Procedure Code 11055, 11056, or 11057 will be included in the Medicare covered foot care services when billed with the appropriate primary diagnosis code, the appropriate secondary diagnosis code, **and** a modifier Q7, Q8, or Q9. When modifier Q7, Q8 or Q9 is not submitted with 11055, 11056 or 11057, then a separate and appropriate primary diagnosis code and the appropriate secondary diagnosis code in order for the service line to be included in the Medicare covered foot care services.

Nondystrophic Nails Coding Criteria

Procedure Code 11719 will be included in the Medicare covered foot care services when billed with the appropriate primary diagnosis code, the appropriate secondary diagnosis code, **and** a modifier Q7, Q8, or Q9. When modifier Q7, Q8 or Q9 is not submitted with 11719, then a separate and appropriate primary diagnosis code and the appropriate secondary diagnosis code in order for the service line to be included in the Medicare covered foot care services.

Debridement of Nail Coding Criteria

Procedure Code 11720 or 11721 will be included in the Medicare covered foot care services when billed with the appropriate primary diagnosis code, the appropriate secondary diagnosis code, **and** a modifier Q7, Q8, or Q9. When modifier Q7, Q8 or Q9 is not submitted with 11720 or 11721, then a separate and appropriate primary diagnosis code and the appropriate secondary diagnosis code in order for the service line to be included in the Medicare covered foot care services.

Utilization Guidelines

- Medicare will cover 11720 and/or 11721 mycotic nail debridement no more often than every 60 days.
- Medicare will cover no more than six 11720 and/or 11721 sessions per patient per 12 months absent medical review of patient records demonstrating medical necessity for the procedure.
- Medicare will not cover 11721 in the absence of a routine foot care exception qualifying condition absent medical review of patient records demonstrating medical necessity for the procedure.

Dystrophic Nails Coding Criteria

Procedure Code G0127 will be included in the Medicare covered foot care services when billed with the appropriate primary diagnosis code, the appropriate secondary diagnosis code, **and** a modifier Q7, Q8, or Q9. When modifier Q7, Q8 or Q9 is not submitted with G0127, then a separate and appropriate primary diagnosis code and the appropriate secondary diagnosis code in order for the service line to be included in the Medicare covered foot care services.

Diabetic Sensory Neuropathy with LOPS Coding Criteria

Diabetic sensory neuropathy with LOPS is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 CFR §411.15(l) (1) (i)). Foot exams for people with diabetic

sensory neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease. For additional information, please reference the reimbursement policy titled *Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (NCD 70.2.1)*.

Procedure Code G0245, G0246, and G0247 will be included in the Medicare covered foot care services when billed with the appropriate primary diagnosis code.

CPT / HCPCS Codes

Code	Description
11055	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
11056	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); two to four lesions
11057	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than four lesions
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method; 1 to 5
11721	Debridement of nail(s) by any method; 6 or more
G0127	Trimming of dystrophic nails, any number
G0245	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (4) patient education
G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education
G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

Modifiers

Code	Description
GX	Notice of liability issued, voluntary under payer policy
GZ	Item or service expected to be denied as not reasonable and necessary
Q7	One Class A finding
Q8	Two Class B findings
Q9	One class B and 2 class C findings

References Included (but not limited to):

CMS NCD(s)

NCD 70.2 Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility

NCD 70.2.1 Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy)

CMS LCD(s)

Numerous LCDs

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CMS Article(s)

Numerous articles

CMS Benefit Policy Manual

Chapter 15, § 290 Foot Care

UnitedHealthcare Medicare Advantage Coverage Summaries

Foot Care Services

UnitedHealthcare Reimbursement Policies

Consultation Services Rendered by a Podiatrist in a Skilled Nursing Facility (NCD 70.2)

Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (NCD 70.2.1)

History

Date	Revisions
10/14/2014	Removed liability modifier references
09/16/2013	Administrative updates
09/11/2013	Re-review of policy approved by MRPC
09/03/2013	Administrative updates
03/28/2012	• Re-review of policy • Administrative updates
04/15/2011	Administrative updates
11/30/2010	Policy developed and published

