Local Coverage Determination (LCD): Routine Foot Care and Debridement of Nails (L33636)

Contractor Information

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National Government Services, Inc.

LCD Information

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CMS National Coverage Policy
Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act
Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862 (a) (1) (A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862 (a) (13)(C) defines the exclusion for payment of routine foot care services.

Code of Federal Regulations (CFR)
Part 411.15., subpart A addresses general exclusions and exclusion of particular services.

CMS Publications:
CMS Publication 100-2, Medicare Benefit Policy Manual, Chapter 15:
    290 Foot care services which are exceptions to the Medicare coverage exclusion.
CMS Publication 100-3, Medicare National Coverage Determination (NCD) Manual Part 1:
    70.2.1 Services provided for diagnosis and treatment of diabetic peripheral neuropathy.
CMS Publication 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 5:
    National Correct Coding Initiative.

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

The Medicare program generally does not cover routine foot care. However, this determination outlines the specific conditions for which coverage may be present.

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 of 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 and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients;
• Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

Indications:

While the Medicare program generally excludes routine foot care services from coverage, there are specific indications or exceptions under which there are program benefits.

Medicare payment may be made for routine foot care when the patient has a systemic disease, such as metabolic, neurologic, or peripheral vascular disease, of sufficient severity that performance of such services by a nonprofessional person would put the patient at risk (for example, a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization in the patient’s legs or feet).

Treatment of warts on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Services normally considered routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.

Treatment of mycotic nails may be covered under the exceptions to the routine foot care exclusion. The class findings, outlined below, or the presence of qualifying systemic illnesses causing a peripheral neuropathy, must be present. Payment may be made for the debridement of a mycotic nail (whether by manual method or by electrical grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit and the physician attending the mycotic condition documents that the following criteria are met:

In the absence of a systemic condition, the following criteria must be met:

• In the case of ambulatory patients there exists:

  Clinical evidence of mycosis of the toenail, and

  Marked limitation of ambulation, pain, and/or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

• In the case of non-ambulatory patients there exists:
Clinical evidence of mycosis of the toenail, and

The patient suffers from pain and/or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

In addition, procedures for treating toenails are covered for the following:

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

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.

The following physical and clinical findings, which are indicative of severe peripheral involvement, must be documented and maintained in the patient record, in order for routine foot care services to be reimbursable.

**Class A findings**
Non-traumatic amputation of foot or integral skeletal portion thereof

**Class B findings**

- Absent posterior tibial pulse
- Advanced trophic changes as evidenced by any three of the following:
  - hair growth (decrease or increase)
  - nail changes (thickening)
  - pigmentary changes (discoloring)
  - skin texture (thin, shiny)
  - skin color (rubor or redness)
- Absent dorsalis pedis pulse

**Class C findings**

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

Note: Benefits for routine foot care are also available for patients 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 patient at risk. If the patient has evidence of neuropathy but no vascular impairment, the use of class findings modifiers is not necessary. This condition would be represented by the ICD-10-
CM codes in the 3rd table of “ICD-10-CM Codes that Support Medical Necessity” listed below.

Limitations:

When the patient's condition is designated by an ICD-10-CM code with an asterisk (*) (see ICD-10-CM Codes That Support Medical Necessity), routine foot care procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service or if the patient had come under a physician’s care shortly after the services were furnished.

The global surgery rules will apply to routine foot care procedure codes 11055, 11056, 11057, 11719, 11720, 11721, and G0127. As a result, 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.

Other Comments:

Medicare does not routinely cover fungus cultures and KOH preparations performed on toenail clippings in the doctor’s office. Identification of cultures of fungi in the toenail clippings is medically necessary only:

- When it is required to differentiate fungal disease from psoriatic nails.
- When a definitive treatment for a prolonged period of time is being planned involving the use of a prescription medication.

For coverage information on Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS), and its relation to coverage of Routine Foot Care Services, refer to Medicare National Coverage Determination (NCD) Manual, Section 70.2.1.

According to this National Coverage Determination, Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, 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. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of 5 tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy.
with loss of protective sensation.
The examination includes:

1. A patient history, and
2. A physical examination that must consist of at least the following elements:
   - Visual inspection of forefoot and hindfoot (including toe web spaces);
   - Evaluation of protective sensation;
   - Evaluation of foot structure and biomechanics;
   - Evaluation of vascular status and skin integrity;
   - Evaluation of the need for special footwear; and
3. Patient education.

**Coding Information**

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 012x Hospital Inpatient (Medicare Part B only)
- 013x Hospital Outpatient
- 022x Skilled Nursing - Inpatient (Medicare Part B only)
- 074x Clinic - Outpatient Rehabilitation Facility (ORF)
- 075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
- 085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes
apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

051X Clinic - General Classification
0940 Other Therapeutic Services - General Classification

CPT/HCPCS Codes

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11055</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE LESION</td>
</tr>
<tr>
<td>11056</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); 2 TO 4 LESIONS</td>
</tr>
<tr>
<td>11057</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THAN 4 LESIONS</td>
</tr>
<tr>
<td>11719</td>
<td>TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER</td>
</tr>
<tr>
<td>11720</td>
<td>DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5</td>
</tr>
<tr>
<td>11721</td>
<td>DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE</td>
</tr>
<tr>
<td>G0127</td>
<td>TRIMMING OF DYSTROPHIC NAILS, ANY NUMBER</td>
</tr>
</tbody>
</table>

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** The use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A30.0</td>
<td>Indeterminate leprosy</td>
</tr>
<tr>
<td>A30.1</td>
<td>Tuberculoid leprosy</td>
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<tr>
<td>A30.2</td>
<td>Borderline tuberculoid leprosy</td>
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<tr>
<td>A30.3</td>
<td>Borderline leprosy</td>
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<tr>
<td>A30.4</td>
<td>Borderline lepromatous leprosy</td>
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<tr>
<td>A30.5</td>
<td>Lepromatous leprosy</td>
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<tr>
<td>A30.8</td>
<td>Other forms of leprosy</td>
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<tr>
<td>A50.41</td>
<td>Late congenital syphilitic meningitis</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>---------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>A50.42</td>
<td>Late congenital syphilitic encephalitis</td>
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<tr>
<td>A50.43</td>
<td>Late congenital syphilitic polyneuropathy</td>
</tr>
<tr>
<td>A50.45</td>
<td>Juvenile general paresis</td>
</tr>
<tr>
<td>A52.11</td>
<td>Tabes dorsalis</td>
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<tr>
<td>A52.13</td>
<td>Late syphilitic meningitis</td>
</tr>
<tr>
<td>A52.14</td>
<td>Late syphilitic encephalitis</td>
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<tr>
<td>A52.15</td>
<td>Late syphilitic neuropathy</td>
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<tr>
<td>A52.16</td>
<td>Charcot's arthropathy (tabetic)</td>
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<td>A52.17</td>
<td>General paresis</td>
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<tr>
<td>A52.19</td>
<td>Other symptomatic neurosyphilis</td>
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<tr>
<td>B35.1</td>
<td>Tinea unguium</td>
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<tr>
<td>D51.0</td>
<td>Vitamin B12 deficiency anemia due to intrinsic factor deficiency</td>
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<tr>
<td>D81.818</td>
<td>Other biotin-dependent carboxylase deficiency</td>
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<tr>
<td>E08.49*</td>
<td>Diabetes mellitus due to underlying condition with other diabetic neurological complication</td>
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<tr>
<td>E08.59*</td>
<td>Diabetes mellitus due to underlying condition with other circulatory complications</td>
</tr>
<tr>
<td>E09.49*</td>
<td>Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication</td>
</tr>
<tr>
<td>E09.59*</td>
<td>Drug or chemical induced diabetes mellitus with other circulatory complications</td>
</tr>
<tr>
<td>E10.49*</td>
<td>Type 1 diabetes mellitus with other diabetic neurological complication</td>
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<tr>
<td>E10.59*</td>
<td>Type 1 diabetes mellitus with other circulatory complications</td>
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<td>E11.49*</td>
<td>Type 2 diabetes mellitus with other diabetic neurological complication</td>
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<td>E11.59*</td>
<td>Type 2 diabetes mellitus with other circulatory complications</td>
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<td>E13.49*</td>
<td>Other specified diabetes mellitus with other diabetic neurological complication</td>
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<tr>
<td>E13.59*</td>
<td>Other specified diabetes mellitus with other circulatory complications</td>
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<tr>
<td>E15.11*</td>
<td>Dry beriberi</td>
</tr>
<tr>
<td>E15.12*</td>
<td>Wet beriberi</td>
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<tr>
<td>E52*</td>
<td>Niacin deficiency [pellagra]</td>
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<tr>
<td>E53.1*</td>
<td>Pyridoxine deficiency</td>
</tr>
<tr>
<td>E53.8*</td>
<td>Deficiency of other specified B group vitamins</td>
</tr>
<tr>
<td>E64.0*</td>
<td>Sequelae of protein-calorie malnutrition</td>
</tr>
<tr>
<td>E75.21</td>
<td>Fabry (-Anderson) disease</td>
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<tr>
<td>E75.22</td>
<td>Gaucher disease</td>
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<tr>
<td>E75.240</td>
<td>Niemann-Pick disease type A</td>
</tr>
<tr>
<td>E75.241</td>
<td>Niemann-Pick disease type B</td>
</tr>
<tr>
<td>E75.242</td>
<td>Niemann-Pick disease type C</td>
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<tr>
<td>E75.243</td>
<td>Niemann-Pick disease type D</td>
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<tr>
<td>E75.248</td>
<td>Other Niemann-Pick disease</td>
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<tr>
<td>E77.0</td>
<td>Defects in post-translational modification of lysosomal enzymes</td>
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<tr>
<td>E77.1</td>
<td>Defects in glycoprotein degradation</td>
</tr>
<tr>
<td>E77.8</td>
<td>Other disorders of glycoprotein metabolism</td>
</tr>
</tbody>
</table>
E85.1 Neuropathic heredofamilial amyloidosis
E85.3 Secondary systemic amyloidosis
E85.4 Organ-limited amyloidosis
E85.8 Other amyloidosis
G04.1 Tropical spastic paraplegia
G11.1 Early-onset cerebellar ataxia
G12.21 Amyotrophic lateral sclerosis
G13.0* Paraneoplastic neuromyopathy and neuropathy
G13.1* Other systemic atrophy primarily affecting central nervous system in neoplastic disease
G35* Multiple sclerosis
G60.0 Hereditary motor and sensory neuropathy
G60.1 Refsum's disease
G60.2 Neuropathy in association with hereditary ataxia
G60.3 Idiopathic progressive neuropathy
G60.8 Other hereditary and idiopathic neuropathies
G61.0* Guillain-Barre syndrome
G61.1* Serum neuropathy
G61.81 Chronic inflammatory demyelinating polyneuritis
G61.89 Other inflammatory polyneuropathies
G62.0* Drug-induced polyneuropathy
G62.1* Alcoholic polyneuropathy
G62.2* Polyneuropathy due to other toxic agents
G62.81 Critical illness polyneuropathy
G62.82* Radiation-induced polyneuropathy
G62.89 Other specified polyneuropathies
G63 Polyneuropathy in diseases classified elsewhere
G64 Other disorders of peripheral nervous system
G65.0 Sequelae of Guillain-Barre syndrome
G65.1 Sequelae of other inflammatory polyneuropathy
G65.2 Sequelae of toxic polyneuropathy
G70.1* Toxic myoneural disorders
G70.81* Lambert-Eaton syndrome in disease classified elsewhere
G73.1* Lambert-Eaton syndrome in neoplastic disease
G73.3* Myasthenic syndromes in other diseases classified elsewhere
G82.21 Paraplegia, complete
G82.22 Paraplegia, incomplete
G82.51 Quadriplegia, C1-C4 complete
G82.52 Quadriplegia, C1-C4 incomplete
G82.53 Quadriplegia, C5-C7 complete
G82.54 Quadriplegia, C5-C7 incomplete
I70.211 Atherosclerosis of native arteries of extremities with intermittent claudication, right leg
I70.212 Atherosclerosis of native arteries of extremities with intermittent claudication, left leg
I70.213 Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs
I70.221 Atherosclerosis of native arteries of extremities with rest pain, right leg
I70.222 Atherosclerosis of native arteries of extremities with rest pain, left leg
I70.223 Atherosclerosis of native arteries of extremities with rest pain, bilateral legs
I70.224 Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.225 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
I70.226 Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.227 Atherosclerosis of native arteries of left leg with ulceration of thigh
I70.228 Atherosclerosis of native arteries of left leg with ulceration of ankle
I70.229 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot
I70.230 Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.231 Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.232 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
I70.233 Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.234 Atherosclerosis of native arteries of left leg with ulceration of ankle
I70.235 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot
I70.236 Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.237 Atherosclerosis of native arteries of other extremities with ulceration
I70.261 Atherosclerosis of native arteries of extremities with gangrene, right leg
I70.262 Atherosclerosis of native arteries of extremities with gangrene, left leg
I70.263 Atherosclerosis of native arteries of extremities with gangrene, bilateral legs
I70.91 Generalized atherosclerosis
I73.00 Raynaud's syndrome without gangrene
I73.01 Raynaud's syndrome with gangrene
I73.1 Thromboangiitis obliterans [Buerger's disease]
I73.81 Erythromelalgia
I73.89 Other specified peripheral vascular diseases
I79.1 Aortitis in diseases classified elsewhere
I79.8 Other disorders of arteries, arterioles and capillaries in diseases classified elsewhere
I80.01* Phlebitis and thrombophlebitis of superficial vessels of right lower extremity
I80.02* Phlebitis and thrombophlebitis of superficial vessels of left lower extremity
I80.03* Phlebitis and thrombophlebitis of superficial vessels of lower extremities, bilateral
I80.11* Phlebitis and thrombophlebitis of right femoral vein
I80.12* Phlebitis and thrombophlebitis of left femoral vein
I80.13* Phlebitis and thrombophlebitis of femoral vein, bilateral
I80.211* Phlebitis and thrombophlebitis of right iliac vein
I80.212* Phlebitis and thrombophlebitis of left iliac vein
I80.213* Phlebitis and thrombophlebitis of iliac vein, bilateral
I80.221* Phlebitis and thrombophlebitis of right popliteal vein
I80.222* Phlebitis and thrombophlebitis of left popliteal vein
I80.223* Phlebitis and thrombophlebitis of popliteal vein, bilateral
I80.231* Phlebitis and thrombophlebitis of right tibial vein
I80.232* Phlebitis and thrombophlebitis of left tibial vein
I80.233* Phlebitis and thrombophlebitis of tibial vein, bilateral
I80.291* Phlebitis and thrombophlebitis of other deep vessels of right lower extremity
I80.292* Phlebitis and thrombophlebitis of other deep vessels of left lower extremity
I80.293* Phlebitis and thrombophlebitis of other deep vessels of lower extremity, bilateral
I82.541* Chronic embolism and thrombosis of right tibial vein
I82.542* Chronic embolism and thrombosis of left tibial vein
I82.543* Chronic embolism and thrombosis of tibial vein, bilateral
I82.811* Embolism and thrombosis of superficial veins of right lower extremities
I82.812* Embolism and thrombosis of superficial veins of left lower extremities
I82.813* Embolism and thrombosis of superficial veins of lower extremities, bilateral
I82.891* Chronic embolism and thrombosis of other specified veins
I89.0 Lymphedema, not elsewhere classified
K90.0 Celiac disease
K90.1 Tropical sprue
K90.2* Blind loop syndrome, not elsewhere classified
K90.3* Pancreatic steatorrhea
K91.2* Postsurgical malabsorption, not elsewhere classified
L60.2 Onychogryphosis
L62 Nail disorders in diseases classified elsewhere
M05.471* Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot
M05.472* Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot
M05.571* Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
M05.572* Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
M05.771* Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement
M05.772* Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement
M05.871* Other rheumatoid arthritis with rheumatoid factor of right ankle and foot
M05.872 Other rheumatoid arthritis with rheumatoid factor of left ankle and foot
M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot
M06.072 Rheumatoid arthritis without rheumatoid factor, left ankle and foot
M06.871* Other specified rheumatoid arthritis, right ankle and foot
M06.872* Other specified rheumatoid arthritis, left ankle and foot
M30.0 Polyarteritis nodosa
M30.2 Juvenile polyarteritis
M30.8 Other conditions related to polyarteritis nodosa
M31.4 Aortic arch syndrome [Takayasu]
M31.7 Microscopic polyangiitis
M34.83 Systemic sclerosis with polyneuropathy
N18.1* Chronic kidney disease, stage 1
N18.2* Chronic kidney disease, stage 2 (mild)
N18.3* Chronic kidney disease, stage 3 (moderate)
N18.4* Chronic kidney disease, stage 4 (severe)
N18.5* Chronic kidney disease, stage 5
N18.6* End stage renal disease

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation: ** For these diagnoses, the patient must be under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service.

Showing 1 to 169 of 169 entries in Group 1

Group 2 Paragraph: For treatment of mycotic nails, or onychogryphosis, or onychauxis, ICD-10 CM code B35.1 or L60.2 respectively, must be reported as primary, with the diagnosis representing the patient’s symptom reported as the secondary ICD-10-CM code. Refer to the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

Secondary Diagnoses to be reported with B35.1 or L60.2 for treatment of mycotic nails, onychogryphosis, and onychauxis to indicate medical necessity:

Group 2 Codes:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L02.611</td>
<td>Cutaneous abscess of right foot</td>
</tr>
<tr>
<td>L02.612</td>
<td>Cutaneous abscess of left foot</td>
</tr>
<tr>
<td>L03.031</td>
<td>Cellulitis of right toe</td>
</tr>
<tr>
<td>L03.032</td>
<td>Cellulitis of left toe</td>
</tr>
<tr>
<td>L03.041</td>
<td>Acute lymphangitis of right toe</td>
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<tr>
<td>L03.042</td>
<td>Acute lymphangitis of left toe</td>
</tr>
<tr>
<td>L60.0</td>
<td>Ingrowing nail</td>
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<tr>
<td>M79.671</td>
<td>Pain in right foot</td>
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<tr>
<td>M79.672</td>
<td>Pain in left foot</td>
</tr>
<tr>
<td>M79.674</td>
<td>Pain in right toe(s)</td>
</tr>
<tr>
<td>M79.675</td>
<td>Pain in left toe(s)</td>
</tr>
<tr>
<td>R26.0</td>
<td>Ataxic gait</td>
</tr>
<tr>
<td>R26.1</td>
<td>Paralytic gait</td>
</tr>
<tr>
<td>R26.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
</tr>
<tr>
<td>R26.81</td>
<td>Unsteadiness on feet</td>
</tr>
</tbody>
</table>
R26.89 Other abnormalities of gait and mobility

**Group 3 Paragraph:** The ICD-10-CM codes below represent those diagnoses where the patient has evidence of neuropathy, but no vascular impairment, for which class findings modifiers are not required.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A30.0</td>
<td>Indeterminate leprosy</td>
</tr>
<tr>
<td>A30.1</td>
<td>Tuberculoid leprosy</td>
</tr>
<tr>
<td>A30.2</td>
<td>Borderline tuberculoid leprosy</td>
</tr>
<tr>
<td>A30.3</td>
<td>Borderline leprosy</td>
</tr>
<tr>
<td>A30.4</td>
<td>Borderline lepromatous leprosy</td>
</tr>
<tr>
<td>A30.5</td>
<td>Lepromatous leprosy</td>
</tr>
<tr>
<td>A30.8</td>
<td>Other forms of leprosy</td>
</tr>
<tr>
<td>A50.43</td>
<td>Late congenital syphilitic polyneuropathy</td>
</tr>
<tr>
<td>A50.45</td>
<td>Juvenile general paresis</td>
</tr>
<tr>
<td>A52.11</td>
<td>Tabes dorsalis</td>
</tr>
<tr>
<td>A52.13</td>
<td>Late syphilitic meningitis</td>
</tr>
<tr>
<td>A52.14</td>
<td>Late syphilitic encephalitis</td>
</tr>
<tr>
<td>A52.15</td>
<td>Late syphilitic neuropathy</td>
</tr>
<tr>
<td>A52.16</td>
<td>Charcot's arthropathy (tabetic)</td>
</tr>
<tr>
<td>A52.17</td>
<td>General paresis</td>
</tr>
<tr>
<td>A52.19</td>
<td>Other symptomatic neurosyphilis</td>
</tr>
<tr>
<td>D81.818</td>
<td>Other biotin-dependent carboxylase deficiency</td>
</tr>
<tr>
<td>E08.49*</td>
<td>Diabetes mellitus due to underlying condition with other diabetic neurological complication</td>
</tr>
<tr>
<td>E09.49*</td>
<td>Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication</td>
</tr>
<tr>
<td>E10.49*</td>
<td>Type 1 diabetes mellitus with other diabetic neurological complication</td>
</tr>
<tr>
<td>E11.49*</td>
<td>Type 2 diabetes mellitus with other diabetic neurological complication</td>
</tr>
<tr>
<td>E13.49*</td>
<td>Other specified diabetes mellitus with other diabetic neurological complication</td>
</tr>
<tr>
<td>E51.11*</td>
<td>Dry beriberi</td>
</tr>
<tr>
<td>E51.12*</td>
<td>Wet beriberi</td>
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<tr>
<td>E52*</td>
<td>Niacin deficiency [pellagra]</td>
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<tr>
<td>E53.1*</td>
<td>Pyridoxine deficiency</td>
</tr>
<tr>
<td>E53.8*</td>
<td>Deficiency of other specified B group vitamins</td>
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<tr>
<td>E75.21</td>
<td>Fabry (-Anderson) disease</td>
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<tr>
<td>E75.22</td>
<td>Gaucher disease</td>
</tr>
<tr>
<td>E75.240</td>
<td>Niemann-Pick disease type A</td>
</tr>
<tr>
<td>E75.241</td>
<td>Niemann-Pick disease type B</td>
</tr>
<tr>
<td>E75.242</td>
<td>Niemann-Pick disease type C</td>
</tr>
</tbody>
</table>
E75.243 Niemann-Pick disease type D
E75.248 Other Niemann-Pick disease
E77.0 Defects in post-translational modification of lysosomal enzymes
E77.1 Defects in glycoprotein degradation
E77.8 Other disorders of glycoprotein metabolism
E85.1 Neuropathic heredofamilial amyloidosis
G04.1 Tropical spastic paraplegia
G11.1 Early-onset cerebellar ataxia
G12.21 Amyotrophic lateral sclerosis
G13.0* Paraneoplastic neuromyopathy and neuropathy
G13.1* Other systemic atrophy primarily affecting central nervous system in neoplastic disease
G35 Multiple sclerosis
G50.0 Hereditary motor and sensory neuropathy
G60.1 Refsum's disease
G60.2 Neuropathy in association with hereditary ataxia
G60.3 Idiopathic progressive neuropathy
G60.8 Other hereditary and idiopathic neuropathies
G61.0* Guillain-Barre syndrome
G61.1* Serum neuropathy
G61.81 Chronic inflammatory demyelinating polyneuritis
G61.89 Other inflammatory polyneuropathies
G62.0* Drug-induced polyneuropathy
G62.1* Alcoholic polyneuropathy
G62.2* Polyneuropathy due to other toxic agents
G62.81 Critical illness polyneuropathy
G62.82* Radiation-induced polyneuropathy
G62.89 Other specified polyneuropathies
G63 Polyneuropathy in diseases classified elsewhere
G64 Other disorders of peripheral nervous system
G65.0 Sequelae of Guillain-Barre syndrome
G65.1 Sequelae of other inflammatory polyneuropathy
G65.2 Sequelae of toxic polyneuropathy
G70.1* Toxic myoneural disorders
G73.3* Myasthenic syndromes in other diseases classified elsewhere
G82.21 Paraplegia, complete
G82.22 Paraplegia, incomplete
G82.51 Quadriplegia, C1-C4 complete
G82.52 Quadriplegia, C1-C4 incomplete
G82.53 Quadriplegia, C5-C7 complete
G82.54 Quadriplegia, C5-C7 incomplete
G95.0 Syringomyelia and syringobulbia
M05.571  Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
M05.572  Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
M34.83   Systemic sclerosis with polyneuropathy

Group 3 Medical Necessity ICD-10 Codes Asterisk Explanation: ** For these diagnoses, the patient must be under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service.

ICD-10 Codes that DO NOT Support Medical Necessity

Additional ICD-10 Information

N/A

**General Information**

Associated Information

**Documentation Requirements:**

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Documentation supporting the medical necessity, such as physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement must be maintained in the patient record.

Physical findings and services must be precise and specific (e.g., left great toe, or right foot, 4th digit.) Documentation of co-existing systemic illness should be maintained.

There must be adequate medical documentation to demonstrate the need for routine foot care services as outlined in this determination. This documentation may be office records, physician notes or diagnoses characterizing the patient’s physical status as being of such severity to meet the criteria for exceptions to the Medicare routine foot care exclusion.

For debridement of mycotic nails, each service encounter, the medical record should contain a description of each nail which requires debridement. This should include, but is not limited to, the size (including thickness) and color of each affected nail. In addition, the local
symptomatology caused by each affected nail resulting in the need for debridement must be documented. For CPT code 11720 documentation of at least one nail will be accepted. For CPT code 11721 complete documentation must be provided for at least 6 nails.

Routine identification of cultures of fungi in the toenail is medically indicated when necessary to differentiate fungal disease from psoriatic nail, or when definitive treatment for prolonged oral antifungal therapy has been planned. If cultures are performed and billed, documentation of cultures and the need for prolonged oral antifungal therapy must be in the patient record and available to Medicare upon request.

**Utilization Guidelines:**

Routine foot care services are considered medically necessary once (1) in 60 days. More frequent services will be considered not medically necessary. 60 day calculations are available at [ngsmedicare/podiatry calculator](https://www.ngsmedicare/podiatry calculator).

Services for debridement of more than five nails in a single day may be subject to special review.

**Appendices:**

Not applicable

Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.


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Empire Medicare Services New York and New Jersey Medical Directors.


**Revision History Information**

N/A

**Associated Documents**

Attachments

N/A
Local Coverage Article:
Routine Foot Care and Debridement of Nails - Supplemental Instructions Article (A52865)

Contractor Information

Contractor Name
National Government Services, Inc.

Article Information

General Information

Article ID
A52865

Original ICD-9 Article ID
A45934

Article Title
Routine Foot Care and Debridement of Nails - Supplemental Instructions Article

AMA CPT / ADA CDT Copyright Statement
CPT only copyright 2002-2013 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Apply to Government Use. Fee

Original Effective Date
10/01/2014

Revision Effective Date
N/A

Revision Ending Date
N/A

Retirement Date
N/A
Article Guidance

Article Text:

The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Routine Foot Care and Debridement of Nails. The LCD can be accessed through our contractor Web site at www.NGSMedicare.com. It can also be found on the Medicare Coverage Database at www.cms.gov/medicare-coverage-database.

Coding Information:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to CCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines
An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

CPT Coding
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.

ICD-10-CM Coding
When reporting debridement of mycotic nails (CPT codes 11720, 11721), the primary diagnosis representing the patient’s dermatophytosis (ICD-10 code B35.1) of the nail must be listed, as well as the secondary diagnosis representing the systemic condition.

In the absence of a systemic condition, claims for debridement of mycotic nails must report the primary diagnosis of dermatophytosis (L60.2), and also report one of the diagnosis codes listed in the "ICD-10-CM Codes that Support Medical Necessity" section of the LCD which indicates secondary infection or pain. A diagnosis of mycotic nails alone is insufficient for payment.

When reporting procedures for treatment of Onychogryphosis or Onychauxis, the primary diagnosis representing one of these conditions must be reported (ICD-10-CM code L60.2), as well as one of the diagnosis codes listed in the “ICD-10-CM Codes that Support Medical Necessity” section of the LCD which indicates secondary infection or pain. A diagnosis of Onychogryphosis or Onychauxis alone is insufficient for payment.

Report these diagnoses for: marked limitation of ambulation (ICD-10-CM code R26.0, R26.1, R26.2, R26.81, R26.89), pain (M79.671, M79.672, M79.674, M79.675, L60.0), secondary infection (L02.611, L02.612, L03.031, L03.032, L03.041, L03.042) resulting from the thickening and dystrophy of the infected toenail plate.

Modifiers:
One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, to indicate the class findings and site:
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.

NOTE: If the patient has evidence of neuropathy, but no vascular impairment, the use of class findings modifiers is not necessary. This condition would be represented by the ICD-10 CM codes listed in the table below under “ICD-10 Codes that are Covered”.

For claims submitted to the Part B MAC:
All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

Modifiers:
For four or fewer modifiers, providers should enter the information in Item 24D of the CMS-1500 claim form or the electronic equivalent. If five or more modifiers are used, the provider should report modifier 99 in Item 24D, and list the modifiers in Item 19 of the CMS-1500 claim form, or electronic equivalent.
Date Last Seen by Attending Physician (for those ICD-10-CM codes which fall under the active care requirement):
The approximate date when the beneficiary was last seen by the M.D., D.O., or qualified non-physician practitioner who diagnosed the complicating condition (attending physician) must be reported in an 8-digit (MM/DD/YYYY) format in Item 19 of the CMS-1500 claim form or the electronic equivalent.

Name and NPI (attending physician):
The NPI of the attending physician must be reported in Item 19 of the CMS-1500 claim form or electronic equivalent.

Places of service:
Claims for routine foot care and debridement of nails services are payable under Medicare Part B in the following places of service: office (11), home (12), assisted living facility (13), group home (14), urgent care (for CPT codes 11720 and 11721 only) (20), inpatient hospital (21), outpatient hospital (22), ambulatory surgical center (24), skilled nursing facility for patients in a Part A stay (31), nursing facility for patients not in a Part A stay (32), custodial care facility (33), independent clinic (49), inpatient psychiatric facility (51), psychiatric facility partial hospitalization (52), community mental health center (53), intermediate care facility (54), residential substance abuse treatment facility (55), psychiatric residential treatment center (56) comprehensive inpatient rehabilitation facility (61), comprehensive outpatient rehabilitation facility (62), end stage renal disease treatment facility (65), state or local public health clinic (71), and adult daycare facility (99).

**For claims submitted to the Part A MAC:**

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- The hospital enters ICD-10-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-10-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient’s symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-10-CM
code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (Z00.00-Z13.9).

- The hospital enters the full ICD-10-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

Home health claims billed on 12X or 22X TOBs do not require HCPCS coding.

Modifiers:
Level two modifiers (indicating digit or limb) are entered in Field Locator 44 UB-04 claim form or the electronic equivalent.

Modifiers identifying indication for treatment (Q7, Q8, or Q9) are entered in Field Locator 44 UB-04 claim form or the electronic equivalent when applicable to validate medical necessity.

Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

<table>
<thead>
<tr>
<th>Bill Type Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td>013x</td>
<td>Hospital Outpatient</td>
</tr>
<tr>
<td>022x</td>
<td>Skilled Nursing - Inpatient (Medicare Part B only)</td>
</tr>
<tr>
<td>074x</td>
<td>Clinic - Outpatient Rehabilitation Facility (ORF)</td>
</tr>
<tr>
<td>075x</td>
<td>Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)</td>
</tr>
<tr>
<td>085x</td>
<td>Critical Access Hospital</td>
</tr>
</tbody>
</table>

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the article services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.
Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

The Revenue Codes Information Table

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>051X</td>
<td>Clinic - General Classification</td>
</tr>
<tr>
<td>0940</td>
<td>Other Therapeutic Services - General Classification</td>
</tr>
</tbody>
</table>

**CPT/HCPCS Codes**

**Group 1 Paragraph:** N/A

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11055</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE LESION</td>
</tr>
<tr>
<td>11056</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); 2 TO 4 LESIONS</td>
</tr>
<tr>
<td>11057</td>
<td>PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THAN 4 LESIONS</td>
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<tr>
<td>11719</td>
<td>TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER</td>
</tr>
<tr>
<td>11720</td>
<td>DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5</td>
</tr>
<tr>
<td>11721</td>
<td>DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE</td>
</tr>
<tr>
<td>G0127</td>
<td>TRIMMING OF DYSTROPHIC NAILS, ANY NUMBER</td>
</tr>
</tbody>
</table>

**ICD-10 Codes that are Covered**

**ICD-10 Codes that are Not Covered**

N/A

**Revision History Information**

N/A
Associated Documents

Related Local Coverage Document(s)
LCD(s)
L33636 - Routine Foot Care and Debridement of Nails opens in new window

Related National Coverage Document(s)
N/A

Statutory Requirements URL(s)
N/A

Rules and Regulations URL(s)
N/A

CMS Manual Explanations URL(s)
N/A

Other URL(s)
N/A

Public Version(s)
Updated on 04/02/2014 with effective dates 10/01/2014 - N/A