

ROUTINE FOOT CARE

Policy

NHP reimburses participating providers for medically necessary foot care services related to the diagnosis and treatment of medical conditions listed in this policy when all of the following conditions exist:

- The patient has a complicating systemic disease indicated by the diagnosis on the claim.
- Physical and/or clinical findings consistent with the systemic diagnosis and indicative of severe peripheral involvement are also documented on the claim, and
- The patient’s condition is such that treatment by a non-professional person would be hazardous (i.e. systemic conditions resulting in severe circulatory embarrassment or areas of desensitization.).
- The member must be seen by a clinician treating the systemic illness at least every six months to be considered in active care.

Prerequisites

Authorization, Notification and Referral

Service	Requirement
Routine Foot Care:	No Prior Authorization, notification or referral required
For HVMA Members	A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care.

Limitations

Routine foot care is covered in accordance with the ICD-9 diagnosis codes contained herein.

Note: This is a more expansive listing than provided in the Prior Authorization Guidelines available on NHP.org.

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

Class findings: A system used by CMS, the American Diabetic Association and the American Podiatric Medical Association to document certain physical and/or clinical findings consistent with the diagnosis and indicating severe peripheral involvement.

Routine foot care: Services including:

- Cutting or removal of corns and calluses
- Trimming, cutting, clipping, or debriding of nails
 - Other hygienic and preventive maintenance care considered self-care (i.e., cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients); and
- Any services involving the foot performed in the absence of localized illness, injury or symptoms

Neighborhood Health Plan Reimburses

- Claims submitted with an appropriate diagnosis supporting the medical necessity of the procedure.
- Medically necessary routine foot care generally once every 60 days.

Neighborhood Health Plan Does *Not* Reimburse

- Claims submitted without a valid ICD-9-CM diagnosis code
- Claims submitted without one of the ICD-9-CM codes listed in this policy that supports medical necessity
- Claims submitted without meeting the documentation requirements listed in this policy

Provider Payment Guidelines and Documentation

Diabetes with neurological manifestations (ICD-9-CM **250.60-250.63**) does **not** require Class Findings.

Based on the presence of a systemic condition, the following documentation is required for routine foot care:

- Diagnosis code of covered condition
- Systemic condition diagnosis code
- Physical / Clinical Class Findings
- Signs and symptoms fall into three classes: A, B, and C

Class A Findings:

- Non-traumatic amputation of foot or integral skeletal portion

Class B Findings:

- Absent posterior tibial pulse;
- Absent dorsalis pedis pulse;
- Advanced trophic changes such as:
 - Hair growth (decrease or absence);
 - Nail changes (thickening);
 - Pigmentary changes (discoloration);
 - Skin texture (thin, shiny);
 - Skin color (rubor or redness).
- *(3 trophic changes are required to meet 1 class finding)*

Class C Findings:

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

To fulfill the coverage requirements for routine foot care the provider must document specific clinical or physical findings in the medical record and summarize on the claim form. Identify class findings on the claim form as follows:

- One Class A Finding; or
- Two Class B Findings; or
- One Class B Finding and two Class C Findings.

Documentation in the medical record must support the medical necessity and frequency of this treatment, including specific evidence that all requirements for coverage are met.

The medical record should provide convincing evidence that nonprofessional performance of the services would have been hazardous to the member due to underlying systemic disease.

Procedures Codes

Note: This list of codes may not be all-inclusive.

Code	Descriptor	Comments
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); 2-4 lesions	
11057	Paring or cutting of benign hyperkeratotic lesion (e.g. Corn or callus); more than 4 lesions	
11719	Trimming of nondystrophic nails, any number	Limit 1 unit per date of service
G0127	Trimming of dystrophic nails, any number	
G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in 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.	

ICD-9 Diagnosis Codes

Diagnosis Code	Descriptor
030.0-030.9	Lepromatous Leprosy (Type L)- Leprosy unspecified
094.0-094.9	Tabes dorsales - neurosyphilis unspecified
249.00-250.93*	Secondary diabetes mellitus w/o mention of complication, not stated as uncontrolled, or unspecified - diabetes w unspecified complication, Type I (juvenile type), uncontrolled
265.2*	Pellagra
272.7	Lipidoses
277.3	Amyloidosis, unspecified

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277.31	Familial Mediterranean fever
277.39	Other amyloidosis
281.0*	Pernicious anemia
286.9	Other and unspecified coagulation defects
340*	Multiple sclerosis
356.0-357.9*	Hereditary peripheral neuropathy - unspecified; Inflammatory and toxic neuropathies
440.20-440.29	Atherosclerosis of native arteries of the extremities unspecified - other atherosclerosis of native arteries of the extremities
443.1	Thromboangitis obliterans (Buerger's Disease)
443.81	Peripheral angiopathy in diseases classified elsewhere
443.9	Peripheral vascular disease unspecified
451.11-451.19*	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial) - phlebitis and thrombophlebitis of other
579.0*	Celiac Disease
579.1*	Tropical Sprue
585.1*	Chronic kidney disease, Stage 1
585.2*	Chronic kidney disease, Stage 2 (mild)
585.3*	Chronic kidney disease, Stage 3 (moderate)
585.4*	Chronic kidney disease, Stage 4 (severe)
585.5*	Chronic kidney disease, Stage 5
585.6*	End Stage Renal Disease
585.9*	Chronic kidney disease, unspecified
956.0-956.9	Injury to sciatic nerve - injury to unspecified nerve of pelvic girdle and lower limb
For diagnosis listed in individual codes or in ranges of ICD-9 codes that support medical necessity marked with an asterisk (), routine foot care is covered only when the patient is under the active care of a clinician who documents the condition in the medical record.	

Related NHP Payment Guidelines

NHP Nail Debridement Provider Payment Guidelines

References

Local Coverage Determination #L3207 R 20, promulgated by NHIC, Corp. for routine foot care services, original effective date: November 30, 1994; effective 5/12/2011. Any changes to the NHIC policy, where appropriate, shall be adopted by reference if not contained in amended versions of this NHP policy.

Publication History

Topic: Routine Foot Care	Owner: Provider Network Management
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2009/09/01 Original documentation

2012/02/01 Authorization grid, cost sharing, references and disclaimer updated

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at prweb@nhp.org.