Routine Foot Care- MEDICARE

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BACKGROUND

CLINICAL BACKGROUND

Individuals with compromised circulation or sensation of the lower extremity are at high risk for causing themselves serious injury when performing routine foot care on their own. These individuals may have difficulty sensing or healing an injury to their feet that may result in painful ulcers or ultimately loss of the limb. Provision of routine foot care services by a medical professional can help prevent adverse outcomes. Routine foot care may include services such as cutting or removal of corns and calluses; trimming, cutting, or debriding nails; hygienic and preventive maintenance foot care. Services may be performed in a physician's office, an outpatient setting, or an individual's home. While diabetes mellitus is a risk factor for foot ulcers, non-diabetic individuals with vascular disease and/or neuropathy are also at increased risk.

POLICY AND CRITERIA

Other sources below are provided for informational purposes, to be used as applicable.

Source	Policy
CMS Coverage Manuals	Medicare Benefit Policy Manual Chapter 15 section 290 – "Foot Care"
National Coverage Determinations (NCD)	For individuals with diabetes mellitus, see NCD 70.2.1 "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (AKA Diabetic Peripheral Neuropathy)"
Local Coverage Determinations (LCD)	L33979 "Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) L38904 "Wound and Ulcer Care"
Local Coverage Article	A57957 "Billing and Coding: Routine Foot Care" A52918 "Coverage of Foot Care Services" A58567 "Billing and Coding: Wound and Ulcer Care"

1. Routine foot care services may be considered medically necessary when the following criteria are met:
    a. Presence of a systemic condition* that has resulted in in severe circulatory insufficiency as evidenced by ANY of the following:
        i. absent posterior tibial pulse by palpation;
        ii. absent dorsalis pedis pulse by palpation;
        iii. lower extremity vascular claudication; OR

b. Presence of a systemic condition* that has resulted in loss of protective sensation in the feet; OR
c. Previous non-traumatic lower extremity amputation (patients qualify for routine foot care of affected or unaffected lower extremity after partial or complete amputation of foot/toes); OR
d. The member is undergoing other treatment for which the foot care is a necessary component (e.g., treatment of warts, fitting for a cast).

2. 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.

3. Treatment of mycotic nails is covered when:
   a. There is clinical evidence of mycosis of the toenail as documented by the attending physician; AND
   b. The patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate OR, if patient is typically ambulatory, there is marked limitation of ambulation attributable to toenail mycosis.

*Examples of systemic conditions that may justify coverage include, but are not limited to, peripheral neuropathies such as those associated with traumatic injury or multiple sclerosis, as well as arteriosclerosis obliterans, chronic thrombophlebitis, and others. For individuals with diabetes mellitus, see NCD (70.2.1) for Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy).

RATIONALE

EVIDENCE BASIS

In their review on prevention of foot ulcers and other serious foot lesions, CMS evaluated primarily evidence related to diabetic foot ulcers. However, other disease processes resulting in peripheral neuropathy and/or peripheral vascular disease face similar potential for benefit. Findings from the CMS review are provided below:

“Comprehensive, multifaceted approaches incorporating multiple interventions that promote greater attention to foot care have been shown to be effectively reduce foot ulcers and other serious foot lesions. Specifically, Litzelman and colleagues were able to reduce serious foot lesions in a randomized controlled trial by utilizing multiple interventions (see Table 3). The intervention was based on two observations (1) basic efforts on the part of the health care provider or patient can reduce the likelihood of subsequent amputation due to diabetes-associated foot disease; and (2) many of these basic procedures are not being systematically applied by health care providers or patients. Over the course of the 12-month study, patients received foot care education and entered into behavioral contracts for desired self-care, which was reinforced with telephone calls and post card reminders. Practice guidelines and informational flow sheets on amputation risk factors were provided to health care providers. Also, patients who received the intervention had special identifiers on their charts to prompt foot examinations and to provide foot care education.

The intervention group (patients in the group that received education on appropriate foot care and whose providers had chart reminders to prompt foot examinations and referral recommendations) was less likely than the control group to have serious foot lesions [baseline prevalence, 2.9%, OR 0.41 (95% CI=0.16-1.00), P = 0.05]. Intervention patients were also more likely to report appropriate self-foot-care behavior, to have foot examinations during office visits (68% compared with 28%; P < 0.001), and to receive foot care education from health care providers (42% compared with 18%; P < 0.001). Finally, physicians in the intervention group were more likely than their control counterparts to examine patients' feet for ulcers, pulses, and abnormal dermatologic conditions and to refer patients to podiatry clinic (10.6% compared with 5.0%; P = 0.04).

In addition, Bild and colleagues noted three studies in which multidisciplinary interventions reduced the frequency of LEAs. In Atlanta, Grady Memorial Hospital instituted an integrated inpatient/outpatient diabetes unit, which included comprehensive podiatry services, nurse clinicians and an extensive education program. The annual number of LEAs in this largely African American and indigent cohort decreased by almost 50%, from 172 in 1973 to an average of 92 per year from 1973 to 1982 among 8000 clinic patients.

In London, England a diabetes foot clinic at Kings College Hospital added podiatrists and shoe fitters to the diabetes foot clinic. Over a two-year period emphasizing podiatric care, antibiotic therapy, and specially constructed shoes, the amputation rate declined 44%. The effect of specially fitted footwear on recurrent ulcers was particularly dramatic. Patients receiving specially fitted footwear had an ulcer recurrence rate of 26%, compared to 83% among those with regular shoes.

Similarly, at the University Hospital of Geneva an 85% reduction in below knee amputations was observed over a 4-year period after the initiation of patient education and training in foot care for people with diabetes. He concluded that the results support the notion that comprehensive foot care, including podiatric care, education and specially fitted shoes[15], can reduce LEAs in individuals with diabetes.[16] As with the Patout study, the observational nature of each of these studies raises doubts about the true magnitude of any beneficial effect. In addition, it is noteworthy that all of these studies addressed multidisciplinary or multifactorial interventions for diabetic feet. Patient education, for example may be a critical component, and was included in most of these programs."

CODES

CPT Code	Description
11055-11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus)
11719	Trimming of nondystrophic nails, any number
11720-11721	Debridement of nail
G0127	Trimming of dystrophic nails, any number

ICD-10 Code and Description	
A52.16	Charcot's arthropathy (tabetic)
B35.1	Dermatophitosis (Tinea unquium)
B37.2	Candidiasis of skin and nail
B52.0	Plasmodium malariae with neuropathy
E08.00 – E13.9	Diabetes Mellitus
O24.011 – O24.93	Diabetes mellitus in pregnancy
G13.0 – G13.1	Systemic atrophy and neuropathy
G6281 – G65.2	Polyneuropathies
G73.3	Myasthenic syndromes in other diseases classified elsewhere
G90.09	Peripheral neuropathy
G99.0	Autonomic neuropathy
I70.201 – I70.799	Atherosclerosis of arteries, lower extremities
I73.00 – I79.8	Peripheral vascular disease
I80.00 – I80.3	Phlebitis and thrombophlebitis, lower extremities
I82.501 – I87.9	Chronic embolism and thrombosis, lower extremities
I89.0	Lymphedema
I99.8	Circulatory system disorder
L02.415 – L03.129	Infections of skin and subcutaneous tissue, lower limb
L11.0	Acquired keratosis follicularis
L60.0 – L60.9	Nail disorders
L84 – L85.2, L86, L87.0, L87.2, L97.501 – L97.529	Disorders of skin and subcutaneous tissue
M05.571 – M05.59	Polyarthropathies

M14.671 – M14.69	Arthropathies, Charcot's joint, ankle and foot
M20.10 – M02.12	Hallus valgus
M34.83	Systemic sclerosis with polyneuropathy
M90.561 – M90.59	Osteonecrosis, lower ley, ankle and foot
M90.861 – M90.89	Osteopathy, lower leg, ankle and foot
Q82.0	Hereditary lymphedema
R20.0 – R20.9	Disorders of skin and subcutaneous tissue
R60.0 – R60.9	Edema