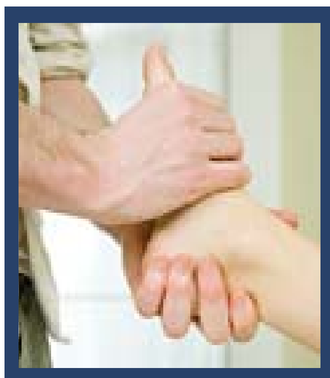
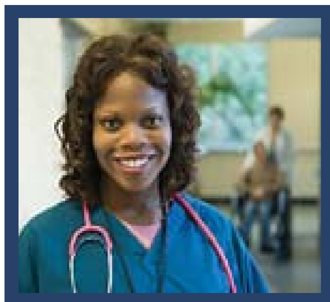
Medicare Podiatry Services

Information for Medicare Fee-for-Service Health Care Professionals

Overview

Podiatry is defined as "the specialty concerned with the diagnosis and/or medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot." (*Stedman's Medical Dictionary* 27th ed.) This can include 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 Podiatry Services

According to the *Medicare Benefit Policy Manual* (MBPM), (Pub 100-2), Chapter 15, Section 290, Medicare Covered Podiatry Services only include medically necessary and reasonable foot care. Any other podiatry services that are offered would be considered routine care and would be classified as either Additional, Mandatory, Supplemental, or Optional Supplemental benefits.

Significant changes have been made in the Summary of Benefits. The category of "Medically Necessary Foot Care and Podiatry Services (Routine care)" has been merged into one category, "Podiatry Services."

Please note that 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.

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 MBPM, Chapter 15, Section 140.

When the routine services are **rendered by a podiatrist**, your Medicare Carrier or Part A/B Medicare Administrative Contractor (A/B MAC) may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen a doctor of medicine (M.D.) or osteopath (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 or A/B MAC 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.

Exclusions from Coverage

Certain foot care related services are not generally covered by Medicare, (though there are some exceptions where certain services will be covered). In general, the following services, whether performed by a podiatrist (DPM), D.O. or M.D., and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare:**

Podiatry Service Excluded	Exception To Exclusions (Covered by Medicare)
Routine Foot Care	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 noncovered care. 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. Mycotic nails – In the absence of a systemic condition, treatment of mycotic nails may be covered when the physician attending the patient's mycotic condition documents that: -There is clinical evidence of mycosis of the toenail, and -The patient has marked limitation of ambulation, [for ambulatory patients] pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition for the following: -Diabetes mellitus -Chronic thrombophlebitis -Peripheral neuropathies involving feet associated with: -- Malnutrition and vitamin deficiency such as malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), and pernicious anemia -- Carcinoma -- Diabetes mellitus -- Drugs and toxins -- Multiple sclerosis -- Uremia (chronic renal disease). Although not intended as a comprehensive list, Chapter 15, Section 290 of the MBPM (Pub 100-2) lists some of the most commonly underlying conditions that might justify coverage for routine foot care.
Flat Foot	None
Subluxation of the Foot	Medical or surgical treatment of subluxation of the ankle joint (talo-crural joint). Reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures.
Supportive Devices for Feet	Orthotic shoes that are an integral part of a leg brace (the expense is included as part of the cost of the brace). Therapeutic shoes for diabetic beneficiaries.
Therapeutic Shoes for Individuals with Diabetes	A narrow **exception** permits coverage of special shoes and inserts for certain patients with diabetes. (MBPM, Chapter 15, Section 140)

Foot Care for Patients with Chronic Disease

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 Manual* (Pub 100-3) Section 70.2.1, for additional information.

Treatments for Wound Care

Electrostimulation for Wounds (Claims submitted on or after 7/6/2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical and electromagnetic stimulation for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. All other uses of electrical and electromagnetic stimulation for the treatment of wounds are noncovered. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence.

Please refer to the National Coverage Decision: NCA for Electrostimulation for Wounds (CAG-00068R) for additional information.

National Coverage Decisions are available at ***http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=28*** 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:

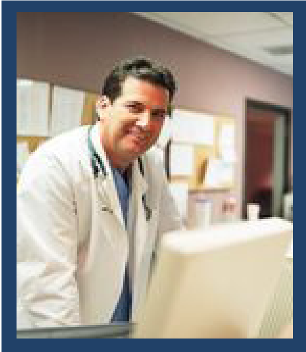
- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

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 National Coverage Determination (CAG-00060N). That document is available at ***http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=37*** on the CMS website.

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.

- 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 noncovered services that are not integrally related to the covered service, the portion of the charges that are attributable to the noncovered services should be denied.

- Sometimes payment is made for incidental noncovered 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.

- 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 MBPM, Chapter 15, Covered Medical and Other Health Services, Section 60 – Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM (Pub 100-2) 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 MBPM, 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, for both feet, even if only one foot suffers from diabetic foot disease.

- Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment MACs (DME MAC). Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B.

Additional Information

Medicare Manuals

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

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

The Medicare Carrier Manual can be found at ***http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021921*** on the CMS website.

The National Coverage Determination Manual can be found at ***http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=national&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS014961*** 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.hhs.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 with Diabetes" can be found at ***http://www.cms.hhs.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.hhs.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.hhs.gov/MedlearnMattersArticles/downloads/mm3430.pdf*** on the CMS website.

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