Local Coverage Determinations

Medicare contractors may use discretion to establish medical policy, known as Local Coverage Determinations (LCDs), pertinent to their areas of jurisdiction.

An LCD consists of only "reasonable and necessary" information. Any information not considered reasonable and necessary (e.g., coding guidelines and reasons for denial) are communicated through each LCD's related article.

As a contractor, TrailBlazer oversees LCD development and reconsideration. More information is available on the LCD Development Process and the steps involved in the LCD Reconsideration Process at these links.

Note: TrailBlazer does not have an LCD for all services/procedures. The service/procedure about which you are trying to obtain information may be covered/non-covered based on other CMS guidelines.

Information about CMS' National Coverage Determinations (NCDs) and the National Non-Covered CPT/HCPCS Codes Lists can be found on the TrailBlazer NCD Web page.

Section 1862 of the Social Security Act applies to all services, even those services that do not have limited coverage due to an LCD or NCD:

"Notwithstanding any other provision of this title, no payment can be made under Part A or Part B for any 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."

Instructions for Accessing LCDs

LCD search results are displayed in sortable columns. The list may be expanded by scrolling to the bottom of the list and clicking "Show All." The results automatically display in alphabetical order according to the LCD title. Click the column heading to sort according to title, effective date, status or last revision.

Important: It is very important to log in when accessing the LCDs. The time allowed for accessing many features such as LCDs is limited unless the user is logged in. Please ensure you have logged in to avoid receiving the CPT licensure agreement numerous times during your session.

LCD Status for J4 Providers

Due to Jurisdiction 4 MAC implementation, major LCD changes occurred for Part A and B Colorado, New Mexico, Oklahoma and Texas between March 1, 2008 and June 13, 2008. The effective dates of the LCD, listed in the "Original Determination Effective Date" field, refer to the date of MAC implementation for the related state and program. Providers should refer to the following chart to determine when to search for a Retired LCD based on the date of service in question:

State and Program	Dates of service prior to:	LCD Search
New Mexico – Part B Oklahoma – Part A and B	March 1, 2008	*Refer to Medicare Coverage Database on the CMS Web site
Colorado – Part B	March 21, 2008	*Refer to Medicare Coverage Database on the CMS Web site
Colorado – Part A New Mexico – Part A Texas – Part A and B	June 13, 2008	Select "Retired" in the Status drop down menu below.
*View the job aid Accessing LCDs from the Medicare Coverage Database.		

LCD Notices

Update – Part B Texas Nerve Conduction Studies...	Date Posted: 11/19/2008
Virginia LCD Updates for October 2008	Date Posted: 10/28/2008
J4 LCD Updates for October 2008	Date Posted: 10/28/2008
J4 LCD Updates for September 2008	Date Posted: 10/16/2008
Virginia LCD Updates for September 2008	Date Posted: 10/16/2008

Routine Foot Care/Mycotic Nail Debridement

Search LCDs/LMRPs

Effective: 3/1/2008
Status: Active
Revision Date: 8/15/2008

LCD Title

Routine Foot Care/Mycotic Nail Debridement – 4P-7AB-R1

Contractor's Determination Number

4P-7AB (L26617)

Contractor Name

TrailBlazer Health Enterprises

Contractor Number

- 04001.
- 04002.

Contractor Type

- MAC – Part A.
- MAC – Part B.

AMA CPT/ADA CDT Copyright Statement

CMS National Coverage Policy

- *Medicare Benefit Policy Manual* – Pub. 100-02, Chapter 15, Section 290.
- *Medicare National Coverage Determinations Manual* – Pub. 100-03, Part 1, Section 70.2.1.
- Correct Coding Initiative – *Medicare Contractor Beneficiary and Provider Communications Manual* – Pub. 100-09, Chapter 5.
- Social Security Act (Title XVIII) Standard References, Sections:
  - 1862(a)(1)(A) Medically Reasonable & Necessary.
  - 1862(a)(1)(D) Investigational or Experimental.
  - 1862(a)(7) Screening (Routine Physical Checkups).
  - 1862(a)(13)(A) Treatment of Flat Foot.
  - 1862(a)(13)(B) Treatment of Subluxation of the Foot.
  - 1862(a)(13)(C) Routine Foot Care.
  - 1833(e) Incomplete Claim.

Primary Geographic Jurisdiction

- CO – 04101.
- NM – 04201.
- OK – 04301.
- TX – 04401:
  - Indian Health Service.
  - End State Renal Disease (ESRD) facilities.
  - Skilled Nursing Facilities (SNFs).
  - Rural Health Clinics (RHCs).
- CO – 04102.
- NM – 04202.
- OK – 04302.
- TX – 04402:
  - Indian Health Service.

Secondary Geographic Jurisdiction

N/A

Oversight Region

- Region VI.

Original Determination Effective Date

03/01/2008

03/21/2008

06/13/2008

Original Determination Ending Date

N/A

Revision Effective Date

08/15/2008

Revision Ending Date

N/A

Indications and Limitations of Coverage and/or Medical Necessity

The *Medicare Benefit Policy Manual,* Pub. 100-02, Chapter 15, Section 290, describes national policy regarding Medicare guidelines for routine foot-care services. The pertinent national policy can be referenced in the attached article.

Excluded Foot-Care Services

The following foot-care services are excluded from Medicare coverage:

- **Treatment of Subluxation of Foot**

National – Reference attached article.

- **Supportive Devices for Feet**

National – Reference attached article.

- **Routine Foot Care**

National – Reference attached article.

- **Treatment of Flat Foot**

National – Reference attached article.

Exceptions to Routine Foot Care Exclusions

Payment may be made as an exception to the routine foot care exclusion if one of the following conditions is met. In addition, as for any other Medicare-covered service, the foot-care service must be reasonable and necessary for the treatment of an illness or injury or to improve the functioning of a malformed body member.

- **Necessary and Integral Part of Otherwise Covered Services**

National – Reference attached article.

- **Treatment of Warts on Foot**

National – Reference attached article.

- **Presence of Systemic Condition**

National – Reference attached article.

- **Mycotic Nails**

Definitive treatment of mycotic nails involves the appropriate use of systemic or topical anti-fungal pharmacologic agents with or without periodic debridement of dystrophic nail plates.

Onychomycosis may present as one or more nail findings, including hypertrophy/thickening, lysis, discoloration, brittleness or loosening of the nail plate. Confirmation of mycotic nail infections by laboratory tests such as fungal cultures and/or stains is usually not indicated. Medicare does not routinely cover fungus cultures and KOH preparations performed on toenail clippings in the doctor's office. Culture identification of fungi in toenail clippings is medically necessary only when culture is required to differentiate fungal disease from psoriatic nails or when treatment involving potentially hazardous medications is planned.

Debridement of nails, whether by electric grinder or manual method, is a temporary reduction in the length and thickness (short of avulsion) of an abnormal nail plate. This is usually performed without anesthesia. The debridement code should not be used if the only part of the nail removed is the distal nail border or other portion of nail not attached to the nailbed.

Treatment of asymptomatic mycotic nails may be covered as routine foot care in the presence of a systemic condition that meets the requirements as previously defined in this LCD (i.e., a qualifying systemic condition).

Treatment of mycotic nails may be covered in the absence of a qualifying covered systemic condition if there is clinical evidence of mycosis of the toenail, and the patient has marked limitation of ambulation, pain, or secondary soft tissue infection resulting from the thickening and dystrophy of the infected nail plate. The treatment of mycotic nails in the absence of a qualifying covered systemic condition will not be covered after the acute symptoms caused by mycosis have abated. National coverage can be referenced in the attached article.

Routine foot-care services to patients who have a coverable condition, the severity of which does not meet the class findings listed in the attached article, are excluded services with the exception of patients who have diabetic ulcers, wounds, infections and sensory neuropathy that is covered only according to the provisions of the following paragraph regarding foot-care services for patients with diabetic sensory neuropathy and LOPS.

- **Foot-Care Services for Patients with Diabetic Sensory Neuropathy and LOPS**

The *Medicare National Coverage Determinations Manual* – Pub. 100-03, Part 1, Section 70.2.1, describes national policy regarding Medicare guidelines for services provided for the diagnosis and treatment of diabetic sensory neuropathy with LOPS. The pertinent national policy can be referenced in the attached article.

HCPCS codes G0245, G0246 and G0247 have been developed for reporting these physician services under this coverage. Codes G0245 and G0246 have been revised to describe them more accurately as E/M services. The new codes are described as:

G0245 Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in LOPS, which must include:

- The diagnosis of LOPS.
- A patient history.
- A physical examination consisting of findings regarding at least the following elements:
  - Visual inspection of the forefoot, hindfoot and toe web spaces.
  - Evaluation of protective sensation.
  - Evaluation of foot structure and biomechanics.
  - Evaluation of vascular status and skin integrity.
  - Evaluation and recommendation of footwear.
  - Patient education.

G0246 Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy

- A patient history.
- A physical examination consisting of findings that includes:
  - Visual inspection of the forefoot, hindfoot and toe web spaces.
  - Evaluation of protective sensation.
  - Evaluation of foot structure and biomechanics.
  - Evaluation of vascular status and skin integrity.
  - Evaluation and recommendation of footwear.
  - Patient education.

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in LOPS to include if present, at least the following:

- Local care of superficial wounds.
- Debridement of corns and calluses.
- Trimming and debridement of nails.

Medicare expects that all routine foot-care services (including treatment of asymptomatic mycotic nails) for patients with diabetic sensory neuropathy **who do not meet the class findings** described in the attached article will be limited to the provisions of the coverage in this section of the LCD.

Note: Type of Bill and Revenue Codes DO NOT apply to Part B.

Coverage Topics

Foot Care

Type of Bill Codes

11X, 12X, 13X, 18X, 21X, 22X, 23X, 71X, 73X, 75X, 85X

Revenue Codes

Note: TrailBlazer has identified the Type of Bill (TOB) and Revenue Center (RC) codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all the CPT/HCPCS codes listed can be billed with all the TOB and/or RC codes listed. CPT/HCPCS codes are required to be billed with specific TOB and RC codes. Providers are encouraged to refer to the CMS *Internet-Only Manual* (IOM) Pub.100-04 *Claims Processing Manual,* for further guidance.

Revenue codes have not been identified for all procedures/services as they can be performed in a number of revenue centers within a hospital, such as emergency room (0450), operating room (0360) or clinic (0510).

CPT/HCPCS Codes

Note:	Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.
11055©	Trim skin lesion
11056©	Trim skin lesions, 2 to 4
11057©	Trim skin lesions, over 4
11719©	Trim nail(s)
11720©	Debride nail, 1–5
11721©	Debride nail, 6 or more
G0127	Trimming dystrophic nails, any number
G0245	Initial foot exam PT LOPS
G0246	Followup eval of foot PT LOPS
G0247	Routine footcare PT W LOPS

ICD-9-CM Codes that Support Medical Necessity

The CPT/HCPCS codes included in this LCD will be subjected to "procedure to diagnosis" editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes 11055, 11056, 11057, 11719 and G0127:**

Covered for:

030.1*	Leprosy, tuberculoid leprosy (type T)
042*	Human immunodeficiency virus [HIV] disease
090.1*	Early congenital syphilis, latent (neurosyphilis)
	Note: Use codes 030.1*, 042*, 090.1* with 357.4 (polyneuropathy in other diseases classified elsewhere).
250.00**–250.03**	Diabetes mellitus without mention of complication
250.10**–250.13**	Diabetes with ketoacidosis
250.20**–250.23**	Diabetes with hyperosmolarity
250.30**–250.33**	Diabetes with other coma

Version: 1.3.2.0

250.40**–250.43**	Diabetes with renal manifestations
250.50**–250.53**	Diabetes with ophthalmic manifestations
250.60**–250.63**	Diabetes with neurological manifestations
250.70**–250.73**	Diabetes with peripheral circulatory disorders
250.80**–250.83**	Diabetes with other specified manifestations
250.90**–250.93**	Diabetes with unspecified complication
265.2**	Pellagra
272.7*	Lipidoses (Fabry's disease)
277.30*	Amyloidosis, unspecified
277.39*	Other amyloidosis
281.0**	Pernicious anemia
	Note: Use codes 265.2*, 272.7*, 277.30*, 277.39*, 281.0* with 357.4 (polyneuropathy in other diseases classified elsewhere).
340**	Multiple sclerosis
344.00–344.04	Quadriplegia
344.09	Other quadriplegia
344.1	Paraplegia
344.30–344.32	Monoplegia of lower limb
355.0–355.6	Mononeuritis of lower limb and unspecified site
355.71	Causalgia of lower limb
355.79	Other mononeuritis of lower limb
355.8–355.9	Unspecified inflammatory and toxic neuropathies
356.0–356.4	Hereditary peripheral neuropathy
356.8–356.9	Unspecified idiopathic peripheral neuropathy
357.0–357.1	Inflammatory and toxic neuropathy
357.2**–357.7**	Polyneuropathy in malignant disease
357.81–357.82	Other, inflammatory and toxic neuropathy
357.9	Unspecified inflammatory and toxic neuropathies
440.20–440.24	Atherosclerosis of native arteries of the extremities
440.29	Other atherosclerosis of native arteries of the extremities
440.30–440.32	Atherosclerosis of bypass graft of the extremities
440.4	Chronic total occlusion of artery of the extremities
443.1	Thromboangiitis obliterans (Buerger's disease)
443.9	Peripheral vascular disease, unspecified
447.9	Unspecified disorders of arteries and arterioles
451.0**	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11**	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19**	Phlebitis and thrombophlebitis of other deep vessels of lower extremities
451.2**	Phlebitis and thrombophlebitis of lower extremities, unspecified
579.0**–579.1**	Intestinal malabsorption
585.4**–585.6**	Chronic kidney disease
	Note: Use codes 579.0*–579.1* and 585.4*–585.6* with 357.4 (polyneuropathy in other diseases classified elsewhere).

For Medicare to cover routine foot care for patients with diagnoses marked by double asterisks (**) in the list above:

- The patient must be under the active care of an MD or DO to qualify for covered routine foot care.

And,

- The patient must have been seen by that physician for the specified condition within six months prior to or six weeks following the foot-care services.
- For the purposes of this LCD, the coverage condition of "active care by a physician" clause above may be satisfied when appropriate care has been rendered by a nurse practitioner, physician assistant or clinical nurse specialist who is licensed by the state to provide such services. References to "MD or DO" or "physician" in regard to the active care clause will include physicians (MDs and DOs), NPs, PAs and CNSs.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes 11720 and 11721:**

services in the presence of a qualifying systemic disease with a primary diagnosis from the following list:

Covered primary diagnoses:

110.1	Onychomycosis
112.3	Candidiasis of the nail
703.8	Other specified diseases of nail
703.9	Unspecified disease of nail

Report covered nail debridement services in the presence of a qualifying systemic disease with a secondary diagnosis from the following list:

Covered secondary diagnoses:

030.1*	Leprosy, tuberculoid leprosy (type T)
042*	Human immunodeficiency virus [HIV] disease
090.1*	Early congenital syphilis, latent (neurosyphilis)
	Note: Use codes 030.1*, 042* and 090.1* with 357.4 (polyneuropathy in other diseases classified elsewhere)
250.00**–250.03**	Diabetes mellitus without mention of complication
250.10**–250.13**	Diabetes with ketoacidosis
250.20**–250.23**	Diabetes with hyperosmolarity
250.30**–250.33**	Diabetes with other coma
250.40**–250.43**	Diabetes with renal manifestations
250.50**–250.53**	Diabetes with ophthalmic manifestations
250.60**–250.63**	Diabetes with neurological manifestations
250.70**–250.73**	Diabetes with peripheral circulatory disorders
250.80**–250.83**	Diabetes with other specified manifestations
250.90**–250.93**	Diabetes with unspecified complication
265.2**	Pellagra
272.7*	Lipidoses (Fabry's disease)
277.30*	Amyloidosis, unspecified
277.39*	Other amyloidosis
281.0**	Pernicious anemia
	Note: Use codes 265.2*, 272.7*, 277.30*, 277.39*, 281.0* with 357.4 (polyneuropathy in other diseases classified elsewhere).
340**	Multiple sclerosis
344.00–344.04	Quadriplegia
344.09	Other quadriplegia
344.1	Paraplegia
344.30–344.32	Monoplegia of lower limb
355.0–355.6	Mononeuritis of lower limb and unspecified site
355.71	Causalgia of lower limb
355.79	Other mononeuritis of lower limb
355.8–355.9	Mononeuritis of lower limb and unspecified site
356.0–356.4	Hereditary peripheral neuropathy
356.8–356.9	Unspecified idiopathic peripheral neuropathy
357.0–357.1	Inflammatory and toxic neuropathy
357.2**–357.7**	Polyneuropathy in malignant disease
357.81–357.82	Other inflammatory and toxic neuropathy
357.9	Unspecified inflammatory and toxic neuropathies
440.20–440.24	Atherosclerosis of native arteries of the extremities
440.29	Other atherosclerosis of native arteries of the extremities
440.30–440.32	Atherosclerosis of bypass graft of the extremities
440.4	Chronic total occlusion of artery of the extremities
443.1	Thromboangiitis obliterans (Buerger's disease)

443.9	Peripheral vascular disease, unspecified
447.9	Unspecified disorders of arteries and arterioles
451.0**	Phlebitis and thrombophlebitis of superficial vessels of lower extremities
451.11**	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial)
451.19**	Phlebitis and thrombophlebitis of other deep vessels of lower extremities
451.2**	Phlebitis and thrombophlebitis of lower extremities, unspecified
579.0**–579.1**	Intestinal malabsorption
585.4**–585.6**	Chronic kidney disease
	Note: Use codes 579.0*–579.1* and 585.4*–585.6* with 357.4 (polyneuropathy in other diseases classified elsewhere).

For Medicare to cover routine foot care for patients with diagnoses marked by double asterisks (**) in the two lists above:

- The patient must be under the active care of an MD or DO to qualify for covered routine foot care.

And,

- The patient must have been seen by that physician for the specified condition within six months prior to or six weeks following the foot-care services.
- For the purposes of this LCD, the coverage condition of "active care by a physician" clause above may be satisfied when appropriate care has been rendered by a nurse practitioner, physician assistant, or clinical nurse specialist who is licensed by the state to provide such services. References to "MD or DO" or "physician" in regard to the active care clause will include physicians (MD and DO), NPs, PAs and CNSs.

Nail Debridement In The Absence Of A Qualifying Systemic Disease: Report covered symptomatic mycotic nail debridement services in the absence of a qualifying systemic disease with a primary diagnosis from the following list:

Covered primary diagnoses:

110.1	Onychomycosis
112.3	Candidiasis of the nail

Report covered symptomatic mycotic nail debridement services in the absence of a qualifying systemic disease with a secondary diagnosis from the following list:

Covered secondary diagnoses:

681.10–681.11	Cellulitis and abscess of toe
703.0	Ingrowing nail
719.7	Difficulty walking
729.5*	Pain in limb
	Note: Use code 729.5* to report the condition of pain resulting from mycotic nails.

Note: If a covered secondary diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes G0245, G0246 and G0247:**

Covered for:

250.60–250.63	Diabetes with neurological manifestations
357.2	Polyneuropathy in diabetes

Note: Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

Diagnoses that Support Medical Necessity

N/A

ICD-9-CM Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

All diagnoses not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this LCD.

Documentation Requirements

- Documentation supporting medical necessity must be legible and available to Medicare upon request.
- For foot-care services covered by virtue of the presence of a qualifying covered systemic disease (asterisked and non-asterisked elsewhere in this LCD), Medicare expects the clinical record to contain a sufficiently detailed clinical description of the feet to provide convincing evidence that non-professional performance of the service is hazardous to the patient. For this purpose, documentation limited to a simple listing of class findings is insufficient. Medicare does not require the detailed clinical description to be repeated at each

instance of routine foot care when an earlier record continues to accurately describe the patient's condition at the time of the foot care. In such cases, the record should reference the location in the record of the previously recorded detailed information. Further, detailed information so referenced should be made available to Medicare upon request.
- For coverage of mycotic nail debridement by reason of the presence of specified conditions (i.e., in the absence of a qualifying covered systemic condition), the record should contain a description of the specified condition beyond a mere mention that the particular condition is present (i.e., painful nails, limited ambulation, infection).
- The patient's record must include the following:
  - Location of each lesion treated.
  - Identification (by number or name) and description of all nails treated.
- To distinguish debridement from trimming or clipping, Medicare expects records to contain some description of the debridement procedure beyond simple statements such as "nail(s) debrided."
- For routine foot care and debridement of multiple symptomatic nails to people who have a qualifying systemic condition, the record should demonstrate the necessity of each service considering the patient's usual activities.
- For debridement of multiple asymptomatic mycotic nails in people who have a qualifying systemic condition, the record should demonstrate the necessity of debridement of each debrided nail considering the patient's usual activities.
- Clinical rationale for treatment of mycotic nails with less than definitive care (i.e., debridement without pharmacologic intervention) should be explained in the record.
- Documentation of foot-care services to residents of nursing homes not performed solely at the request of the patient or patient's family/conservator must include a current nursing facility order (dated and signed with date of signature) for routine foot care service issued by the patient's supervising physician that describes the specific service necessary. Such orders must meet the following requirements:
  - The order must be dated and must have been issued by the supervising physician prior to foot-care services being rendered.
  - Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within a reasonable period of time following issuance of the order.
  - The order must be consistent with the attending physician's overall plan of care.
  - The order must be for medically necessary services to address a specific patient complaint or physical finding.
  - Routinely issued or "standing" facility orders for routine foot-care services and orders for non-specific foot-care services that do not meet the above requirements are insufficient.
- Documentation of foot-care services to residents of nursing homes performed solely at the request of the patient or patient's family/conservator should name the person who requested the services and should identify the requesting person's relationship to the patient.
- The following documentation requirements for HCPCS codes G0245, G0246 and G0247 are provided by CMS:
  - For codes G0245, G0246 and G0247, the medical record must include documentation of performance of all elements listed in the code descriptions.
  - For code G0245, the patient history should include, but is not limited to, how, when and by whom the diagnosis of LOPS was made, as well as any pertinent present and/or past history regarding the feet).
  - For code G0246, the patient history should include, at the least, an interval history regarding the feet since the previous evaluation.
  - For code G0247, the description of routine foot-care services contains similar information as other covered routine foot-care services listed above.
  - For codes G0245 and G0246, record the educational methods and the identity of the educator.

Appendices

N/A

Utilization Guidelines

The frequency of routine foot care varies among patients. Medicare will cover routine foot care as often as is medically necessary but no more often than every 60 days.

Regarding nail debridement, the frequency of medically necessary nail debridement, the number of affected nails requiring debridement and the duration of repeating medically necessary debridements vary among patients.

- Medicare will cover mycotic nail debridement as often as is medically necessary but no more often than every 60 days.
- Most patients require debridements less frequently than every 60 days.
- Repetitive debridement of symptomatic mycotic nails (meeting the requirements in the attached article) in the absence of a qualifying systemic condition is rarely required.
- Debridement of multiple symptomatic mycotic nails (meeting the requirements listed in the attached article) in the absence of a qualifying systemic condition is rarely required.
- Medicare expects patients will be treated definitively when medically appropriate.
- Fungal nail infections that are successfully treated with pharmacologic agents will require limited debridement in terms of frequency and duration.

Each physician or physician group of which that physician is a member, may only receive reimbursement once for G0245 for each beneficiary. However, if that beneficiary needs to see a new physician, that new physician may also be reimbursed once for G0245 for that beneficiary as long as it has been at least six months from the last time G0245 or G0246 was paid for the beneficiary, regardless of who provided the service.

Sources of Information and Basis for Decision

J4 (CO, NM, OK, TX) MAC Integration

TrailBlazer adopted the TrailBlazer LCD, "Routine Foot Care," for the Jurisdiction 4 (J4) MAC transition, with addition of applicable diagnosis codes from the NAS LCD.

Full disclosure of sources of information is found with original contractor LCDs.

Other Contractor Local Coverage Determinations

"Routine Foot Care/Mycotic Nail Debridement," TrailBlazer LCD, (00400) L12481, (00900) L12473.

"Treatment of Ulcers and Symptomatic Hyperkeratoses," Noridian Administrative Services, LLC LCD, (CO) L23770.

"Routine Foot Care," Noridian Administrative Services, LLC LCD, (CO) L23756.

"Routine Foot Care," Arkansas BlueCross BlueShield (Pinnacle) LCD, (NM, OK) L11701 and L11826.

Start Date of Notice Period

12/20/2007

Revision History

Number	Date	Explanation
R1	08/15/2008	Revised second bullet point in the "Coding Guidelines" section of the Article to require reporting the NPI number (instead of the UPIN) of the treating physician. Effective date: 05/23/2008.
N/A	06/13/2008	LCD effective in TX Part A and Part B and Part A CO and NM 06/13/2008
N/A	03/21/2008	LCD effective in CO Part B 03/21/2008
N/A	03/01/2008	LCD effective in NM Part B and OK Part A and Part B 03/01/2008
	02/22/2008	Clarifying information regarding **mandatory use of primary and secondary diagnoses** for **CPT/HCPCS codes 11720 and 11721** when qualifying systemic disease is present and when it is not, added to LCD. Use of ICD-9-CM Coding List "A" and "B" removed. **Effective for each state based upon cutover date.**
	12/20/2007	Consolidated LCD posted for notice effective: 12/20/2007

This content pertains to...

Programs: Part A,Part B
Topics: Not Topic Specific
Subtopics: Not Subtopic Specific