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## **1.0 Description of the Service**

Medically necessary routine foot care is the cutting or removal of corns and calluses; trimming, cutting, clipping, or debriding of nails; and other hygienic care due to a physical or clinical finding that is consistent with a metabolic, neurological, and/or peripheral vascular disease diagnosis and indicative of severe peripheral involvement.

**Note:** In the absence of medical necessity, these services are considered routine and are not covered by the N.C. Medicaid program.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

#### **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best

condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

*EPSDT provider page:* <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### 3.0 When the Service Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### 3.1 General Criteria

Medicaid covers medically necessary routine foot care when

- a. the procedures are medically necessary;
- b. the procedures are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- c. the procedures can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- d. the procedures are furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

#### 3.2 Medical Necessity Criteria

Medically necessary routine foot care services will be covered **only** when:

- a. they are an integral part of otherwise covered services such as plantar warts (refer to Clinical Coverage Policy #1C-1, Podiatry Services); or
- b. documentation illustrates the presence of metabolic, neurological, and/or peripheral vascular disease or provides evidence of specific active complications resulting from prior insults due to the aforementioned systemic conditions; or
- c. there is evidence of mycotic nail infection that in the absence of a systemic condition results in intolerable pain or secondary infection.

The recipient must be under the active care of a physician for the systemic condition.

**Note:** Curettement or shavings of lesion procedures are reviewed to determine if the service is routine foot care.

## 4.0 When the Service Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 4.1 General Criteria

Medically necessary routine foot care is not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure unnecessarily duplicates another provider's procedure; or
- d. the procedure is experimental, investigational, or part of a clinical trial.

### 4.2 Routine Foot Care

In the absence of medical necessity, these services are considered routine and are not covered by the N.C. Medicaid program.

## 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 5.1 Prior Approval

Prior approval for medically necessary routine foot care is not required, except for recipients with MPW coverage, to document medical necessity for services related to pregnancy or due to complications of pregnancy. Prior approval is obtained using the Medicaid Request for Prior Approval Form 372-118.

## 6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for medically necessary routine foot care when the procedures are within the scope of their practice.

## 7.0 Additional Requirements

Documentation to substantiate the condition must be present in the medical record and kept on file for a period of not less than five years. Documentation must

- a. support the services rendered to the recipient;
- b. indicate when the recipient last saw the medical doctor, doctor of osteopathy, or nurse practitioner for treatment of the severe peripheral complication; and
- c. include the referring physician's name.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 1988

**Revision Information:**

Date	Section Updated	Change
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
2/1/07	Attachment A	Corrected a diagnosis code (from 759.5 to 729.5) in Section B, #2.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
8/1/07	Attachment A, Letter B	Corrected a diagnosis code (from 719.77 to 719.7).

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### A. Claim Type

Physicians, emergency department physicians, medical clinics, individual podiatrists, nurse practitioners, and health departments enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.

### B. Diagnosis Codes

1. Providers must bill the appropriate ICD-9-CM diagnosis code that supports medical necessity. Diagnostic codes must be billed at their highest level of specificity.
2. Debridement of nail(s) for a patient with infected mycotic nails and a systemic condition or marked ambulatory limitations due to pain or infection are covered for primary ICD-9-CM diagnosis code 110.1 and the appropriate secondary diagnosis 681.10, 681.11, 719.7, 729.5, or 781.2.

### C. Procedure Code(s)

The relevant procedure codes are as follows.

Procedure Code	Description
<b>CPT Procedure Codes</b>	
11055	Paring or cutting of benign hyperkeratotic lesion; single lesion
11056	Paring of cutting of benign hyperkeratotic lesion; two to four lesions
11057	Paring of cutting of benign hyperkeratotic lesion; more than four lesions
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method(s); one to five
11721	Debridement of nail(s) by any method(s); six or more
<b>HCPCS Procedure Code</b>	
G0127	Trimming of dystrophic nails, any number

**Note:** When billing G0127 for trimming of dystrophic nails include on the claim an ICD-9-CM diagnosis code describing the recipient's systemic condition. The billing unit = 1 regardless of the number of nails that are trimmed.

### D. Modifiers

Providers are required to follow applicable modifier guidelines. Class findings refer to certain categories of physical and/or clinical findings consistent with the diagnosis given and indicative of severe peripheral involvement. The relevant modifiers are as follows.

Modifier	Description
Q7	One Class A finding
Q8	Two Class B" findings
Q9	One Class "B" findings and two Class "C" findings

**E. Place of Service**

Place of Service Code	Description
05	Indian Health Service—free-standing facility
06	Indian Health Service—provider-based facility
11	Office
12	Home (private residence)
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room—hospital
24	Ambulatory surgery center
25	Birth center
26	Military treatment facility
31	Skilled nursing facility
33	Custodial care facility
34	Hospice
50	Federally qualified health center (FQHC)
51	Inpatient psychiatric facility
52	Psychiatric facility—partial hospitalization
53	Community mental health center
54	Intermediate care facility (ICF)
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment facility
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End-stage renal disease treatment facility
71	State or local health department clinic/public health clinic
72	Rural health clinic

**F. Reimbursement**

Providers must bill usual and customary charges.

**G. Co-payments**

Medically necessary routine foot care services are subject to a \$3.00 co-payment for office visits for recipients age 21 and over. For additional information on co-payments and co-payment exemptions, refer to the Basic Medicaid Billing Guide on DMA's Web site at <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.