



Colorado Medicaid Benefit Coverage Standard

PODIATRY SERVICES

Brief Coverage Statement

Podiatric medicine and surgery is the diagnosis and treatment of foot and ankle ailments in adults, children, and infants.

The practice of podiatry may include the suggesting, recommending, prescribing, or administering of any podiatric form of treatment, operation, or healing for the intended palliation, relief, or cure of any disease, ailment, injury, condition, or defect of the human toe, foot, ankle, tendons that insert into the foot, and soft tissue wounds below the mid calf, including complications thereof consistent with such scope of practice.

1. Soft tissue wound is defined as a lesion to the musculoskeletal junction that includes dermal and sub-dermal tissue that does not involve bone removal or repair or muscle transfer.
2. Mid-calf is defined as 50% of the total distance between the talus and tibial plateau.

It may include partial amputation of the foot, but it does not involve the complete amputation, or disarticulation between the talus and the tibia, or the administration of an anesthetic, other than a local anesthetic.

Routine Foot Care is the cutting or removal of corns and calluses; trimming, cutting, or debriding of nails; and other hygienic care due to a physical or clinical finding that is consistent with a metabolic, neurological, or peripheral vascular disease diagnosis and indicative of significant peripheral involvement.

Services Addressed in Other Policies

- None

Eligible Providers

Providers enrolled with Colorado Medicaid.



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Eligible Places of Service

- Independent/Assisted Living
- Clinic
- Outpatient Hospital
- Skilled Nursing Facility
- Federally Qualified Health Center
- Office
- Rural Health Center
- Client's Home
- Ambulatory Surgery Center
- Group Home
- Nursing Home

Eligible Clients

1. All Colorado Medicaid-enrolled clients, who have documented medical conditions listed in the Covered Services section.
2. Clients enrolled programs that require a referral for specialist services (e.g. the Primary Care Physician Program, the Accountable Care Collaborative) must obtain a referral to a specialist for services to be reimbursed.

Covered Services and Limitations

Colorado Medicaid covers the examination, diagnosis, and treatment of the foot and ankle when medically necessary as described in 10 C.C.R. 2502-10 Section 8.076.1.8. Examples of foot/ankle treatment covered include treatment of fractures, infections, sprains/strains, symptomatic or limiting foot deformity, and trauma injury.

Routine foot care services are covered services when specified criteria are met and the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the client's needs.

Examples of routine foot care services covered include debridement or reduction of pathological toenails, or infected or painful corns and calluses.

Routine foot care services will be covered **only** when:

1. They are an integral part of otherwise covered services such as skin pathology, or
2. 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 systemic conditions, or
3. There is evidence of pathologic nail infection that in the absence of a systemic condition results in intolerable pain or secondary infection.

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



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Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parenthesis) most commonly represent the underlying conditions which may justify coverage for routine foot care:

1. Diabetes Mellitus
2. Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, or occlusive peripheral arteriosclerosis)
3. Buerger's Disease (thromboangiitis obliterans)
4. Chronic thrombophlebitis
5. Peripheral neuropathies involving the feet associated with:
 - 5.1. Malnutrition and vitamin deficiency
 - 5.2. Malnutrition (general, pellagra)
 - 5.3. Alcoholism
 - 5.4. Amyloid Neuropathy
 - 5.5. Pernicious Anemia
 - 5.6. Traumatic Injury
 - 5.7. Hereditary Disorders
 - 5.8. Angiokeratoma Corporis Diffusum (Fabry's)
 - 5.9. Carcinoma
 - 5.10. Diabetes Mellitus
 - 5.11. Drugs and Toxins
 - 5.12. Multiple Sclerosis
 - 5.13. Uremia (Chronic Renal Disease)
 - 5.14. Leprosy or Neurosyphilis
 - 5.15. Hereditary Sensory Radicular Neuropathy
 - 5.16. Malabsorption (Celiac Disease, Tropical Sprue)

Prior Authorization Requirements

Prior authorization is not required for the routine foot services outlined within the Covered Services and Limitations section. Debridement or reduction of nails, corns, and calluses for clients performed more frequently than a 60 day interval will be subject to post payment review for medical necessity and compliance with policy requirements. Documentation substantiating services received more frequently than once every 60 days must be stored in the client's medical record.

All documentation to substantiate medical conditions that permit routine foot care to be rendered must be present in the medical record and kept on file for a period of six years. Providers must follow the Medicare guidelines for documentation. Documentation must:

1. Support the services rendered to the client;
2. Indicate when the client last saw the medical doctor, doctor of osteopathy, physician assistant, or nurse practitioner for treatment of the severe peripheral complication; and
3. Include the referring physician's name.



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Non-Covered Services and General Limitations

NON-COVERED SERVICES

Routine foot care services are not covered when:

1. The client does not meet the specific criteria listed above;
2. The client or caregiver is capable of performing routine foot care without risk of injury;
3. The procedure duplicates another provider's procedure during the 60 day interval; or
4. The procedure is experimental, investigational, or part of a clinical trial.

Note: Curettage procedures or shaving of lesions are not covered except as described in Covered Services and Limitations.

The following list includes, but is not limited to, podiatry services which are not covered by Colorado Medicaid:

1. Surgical assistant services (differing from assisting surgeons).
2. Local anesthetics that are billed as a separate procedure.
3. Operating room facility charges for in office procedures.
4. Routine foot care:
 - 4.1. Foot hygiene (cleaning and soaking the feet to maintain a clean condition);
 - 4.2. Cutting or removal of corns and calluses (except as described in Covered Services and Limitations);
 - 4.3. Trimming, cutting, clipping or debriding of nails (except as described in Covered Services and Limitations);
 - 4.4. Use of skin creams to maintain skin tone; or
 - 4.5. Any other service performed in the absence of localized illness, injury or symptoms involving the foot.
5. Services not covered by Medicare, or services denied by Medicare:
 - 5.1. Subluxation of the foot;
 - 5.2. Treatment of flat feet; or
 - 5.3. Routine supplies provided in the office.

GENERAL LIMITATIONS

1. When a physician or podiatrist provides podiatric services to clients in long term care (LTC) facilities, the referral must result from the client residing in the LTC facility, an RN, or LPN employed by the facility, the client's family, guardian, or attending physician. LTC facilities are responsible to arrange for podiatric services provided by a Doctor of Podiatric Medicine and must document the referral in the medical record.
2. Coverage for the debridement and reduction of nails, corns, and calluses (procedure codes 11042, 11045, 11055, 11056, 11057, 11720, 11721) are limited to once every 60 days. A



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provider may provide both debridement and reduction of nails at the same visit. Once a client has received either a debridement or reduction of nails or both either service is not available for 60 days after the treatment.

3. For established patients, an evaluation and management visit charge must not be billed on the same day as the date for services described for debridement or reduction of nails, corns, and calluses unless there is another separately identifiable service or procedure documented in the medical record.
4. For dually eligible Medicare and Medicaid clients, routine foot care services covered by Medicaid but not Medicare must be billed using the GY modifier.
5. Avulsion of toenail plate (procedure codes 11730 and 11732): An ingrown nail is a condition which results in the growth of the nail edge into the surrounding soft tissue, resulting in acute inflammation or pain, or ischemic soft tissue changes. An infection may or may not be present. Providers may bill for avulsions involving the removal of the entire nail or a portion thereof without destruction of the nail matrix. Re-growth of the nail usually requires at least 4 months. Services for avulsion more frequently than a four month interval will be subject to post payment review for medical necessity and compliance with policy requirements. Documentation substantiating services received more frequently than once every four months must be stored in the client's medical record.
6. Excision of nail and matrix for permanent removal (11750) can only be billed once per toe. Excision of nail and nail matrix requires removal of part or the entire nail along its length, with destruction or permanent removal of the matrix by any means. Only one code is billed at a time per toe regardless of how much nail is removed, even if bilateral sides of the same nail are removed.
7. Excision (procedure codes 10060 and 10061): Providers may bill for excision codes using toe modifiers or if the procedure is not on a toe (use Rt or Lt). When a patient requires these procedures to be performed more than once, the medical record must reflect the reason for persistent or recurrent infections and a plan for future preventative measures being taken.

Modifiers

TA	Left foot, great toe	T5	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	T8	Right foot, fourth digit
T4	Left foot, fifth digit	T9	Right foot, fifth digit



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Definitions

Term	Definition
Systemic Condition	A condition that affects one or more parts or organs of the body, other than those parts found in the toe, foot, ankle, and/or tendons that insert into the foot.

References

Colorado Medicaid Medical/Surgical Services Billing Manual:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251623889127&ssbinary=true> Accessed May 19, 2010

Colorado Medicaid Prior Authorization Form:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251623889127&ssbinary=true> Accessed May 19, 2010

Medicare Benefit Policy Manual. Chapter 15 – Covered Medical and Other Health Services, Section 290, “Footcare.” (Rev. 151, 11-18-11).

State of Colorado regulations on Podiatric Practice: Colorado Podiatry Board Rules and Regulations Further Defining the Scope of the Practice of Podiatry in Colorado Rule 290 of Sections 12-32-104(1)(a) and 24-4-103, C.R.S. effective May 1, 2005 at:

<http://www.dora.state.co.us/podiatrists/rules/290.pdf> Accessed May 19, 2010

Medicaid Director Signature

Date