

Foot Care Guidelines

MEDICAL POLICY NUMBER: 368

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

PLAN PRODUCT AND BENEFIT APPLICATION

Commercial

Medicaid/OHP*

Medicare**

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Foot Care: Covered on specific lines for specific pairings of the prioritized list

High Risk Foot Care: Guideline Note 232

**Medicare Members

This Company policy may be applied to Medicare Plan members only when directed by a separate Medicare policy. Note that investigational services are considered “**not medically necessary**” for Medicare members.

COVERAGE CRITERIA

Notes: Member benefit language, which addresses excluded routine foot care services, may vary. Member benefit contract language takes precedent over medical policy.

- I. Foot care services may be considered **an exception to routine foot care exclusions** when **any** of the following situations (A.-D.) apply (See [Policy Guidelines](#) below for a list of “routine foot care” services):
 - A. Routine foot care that is necessary and an integral part of an otherwise covered service (e.g., routine foot care services required to diagnose and treat ulcers, wounds, fractures, or infections). (See the “**IMPORTANT NOTE**” below Criterion I); **or**
 - B. Treatment of warts (e.g., plantar warts) on the feet; **or**
 - C. Routine foot care services performed with the presence of systemic conditions, such as metabolic, neurologic, or peripheral vascular disease (See [Policy Guidelines](#) below) and when non-professional performance of the service would be hazardous for the patient because of an underlying systemic disease; **or**
 - D. Treatment of mycotic nails in **either** of the following (1 or 2).
 1. In the *presence* of systemic conditions as noted above in Criterion I.C.
 2. In the *absence* of systemic conditions:
 - a. For an ambulatory patient, documentation must support that the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

b. For a non-ambulatory patient, documentation must support that the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of an infected toenail plate.

IMPORTANT NOTE: Services that are integral to other procedures are not generally allowed separate reimbursement. Therefore, while the service may be considered necessary, separate allowance or payment is not guaranteed. (Example: If trimming of toenails is required to effectively apply a cast to a fractured foot, a portion of a single submitted charge will not be separated out and denied for the work associated with the trimming of the nails. However, if a separately itemized charge for the nail trim service is submitted, it will be denied.)¹

II. Foot care services are considered **routine foot care and not a covered benefit** when Criterion I. above is not met.

Link to [Evidence Summary](#)

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes demonstrating the patient's physical status as being of such severity to meet the criteria for exceptions to the routine foot care exclusion.
 - Physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement.
 - Documentation of conditions and procedures must be precise and specific (e.g., left great toe, right foot 4th digit, etc.).
 - Documentation which demonstrates the condition warrants a provider rendering these services and that failure to provide such professional services would be hazardous to the member due to their underlying medical condition(s).

This policy may be primarily based on the following Center for Medicare and Medicaid Services (CMS) guidances:

- Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, [§290 - Foot Care](#) (*see the following subsections for the relevant topic*):

- B. Exclusions from Coverage, 2. Routine Foot Care
- C. Exceptions to Routine Foot Care Exclusion
- D. Systemic Conditions That Might Justify Coverage
- F. Presumption of Coverage
- Application of Foot Care Exclusions to Physician's Services
- Local Coverage Determination (LCD): Wound and Ulcer Care [L38902](#)
- Local Coverage Article (LCA): Billing and Coding: Routine Foot Care ([A57954](#))
- National Coverage Determination (NCD) for Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) ([70.2.1](#))

General

According to the Medicare Benefit Policy Manual:

“...Services that normally are considered routine and not covered by Medicare include the following:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.”

However, there are exceptions to the routine foot care exclusion, which include:

1. Foot care services which are necessary and integral parts of otherwise covered services.
2. Treatment of warts on the feet.
3. Foot services required with the presence of a systemic condition (e.g., diabetes).
4. Treatment of mycotic nails.

Systemic Conditions

Medicare lists systemic conditions which may justify the medical necessity and coverage for routine foot care. The following metabolic, neurologic, and peripheral vascular diseases represent some of the most common underlying conditions that might justify coverage for routine foot care (**NOTE:** This is not intended to be a comprehensive list)¹:

- Diabetes mellitus *
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis *
- Peripheral neuropathies involving the feet -
 - Associated with malnutrition and vitamin deficiency *

- Malnutrition (general, pellagra)
- Alcoholism
- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia
- Associated with carcinoma *
- Associated with diabetes mellitus *
- Associated with drugs and toxins *
- Associated with multiple sclerosis *
- Associated with uremia (chronic renal disease) *
- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders
 - Hereditary sensory radicular neuropathy
 - Angiokeratoma corporis diffusum (Fabry's)
 - Amyloid neuropathy

For conditions designated by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) who documents the condition.

Foot Care for Diabetic Sensory Neuropathy: Loss of Protective Sensation (LOPS)

Medicare allows an evaluation (examination and treatment) of the feet no more frequently than every six (6) months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, but only when the patient has **not** seen a foot care specialist for another reason during that 6-month period. The diagnosis of diabetic sensory neuropathy with LOPS should already be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and ruled out by the primary care physician prior to initiating or referring for foot care for persons with LOPS.^{2,3}

Presumption of Coverage

In evaluating whether the coverage requirements routine foot services are met, a presumption of coverage may be made where the clinical documentation and medical record discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For purposes of applying this presumption, the following findings are pertinent:

Class A Findings

- Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B Findings

- Absent posterior tibial pulse;

- Advanced trophic changes as: hair growth (decrease or absence) nail changes (thickening) pigmentary changes (discoloration) skin texture (thin, shiny) skin color (rubor or redness) (Three required); and
- Absent dorsalis pedis pulse.

Class C Findings

- Claudication;
- Temperature changes (e.g., cold feet);
- Edema;
- Paresthesias (abnormal spontaneous sensations in the feet); and
- Burning.

The presumption of coverage applies when the provider rendering the routine foot care has identified and documented:

- A. A Class A finding;
- B. Two of the Class B findings; or
- C. One Class B and two Class C findings.

Complaints of Pain

According to Noridian:

“... foot care services associated with a patient's complaints of pain would not be considered routine in nature. Pain may indicate a problem, such as an ulcer or infection, which is necessary to evaluate. If pain is associated with the reason for the foot care, it is reasonable and necessary for the medical professional to assess and evaluate the pain, and subsequently treat both the pain and the cause of the pain if possible.”⁴

Application of the Foot Care Exclusion to Physician's Services

The exclusion of foot care is determined by the nature of the service, regardless of the type of clinician who provides the service. Coverage is not determined by the difficulty or complexity of the procedure.

It is expected that relatively few claims for routine-type foot care are anticipated considering the severity of conditions contemplated as the basis for this exception. Medicare states, “[c]laims for this type of foot care should not be allowed in the absence of convincing evidence that nonprofessional performance of the service would have been hazardous for the beneficiary because of an underlying systemic disease.”

REGULATORY STATUS

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

BILLING GUIDELINES AND CODING

CPT codes 11055, 11056 and 11057 describe treatment of hyperkeratotic lesions (e.g., corns and calluses).

Coverage of claims for CPT codes 11055, 11056, 11057, 11719, 11720, 11721, and G0127 is made in accordance with the billing guidance and diagnosis code lists provided by Noridian in the LCA [A57954](#), with additional considerations provided by LCA [A58565](#) (*LCA: Billing and Coding: Wound and Ulcer Care*; for CPT codes 11055-11057.

HCPCS Code S0390

HCPCS code S0390 is not recognized as a valid code for claim submission as indicated in the relevant Company Coding Policy (*HCPCS S-Codes and H-Codes*, 22.0). Providers need to use alternate available CPT or HCPCS codes to report for this service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service addressed in this policy, it will be denied as not covered.

CODES*		
CPT	11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
	11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions
	11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions
	11719	Trimming of nondystrophic nails, any number
	11720	Debridement of nail(s) by any method(s); 1 to 5
	11721	Debridement of nail(s) by any method(s); 6 or more
HCPCS	G0127	Trimming of dystrophic nails, any number
	S0390	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.

- See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, §290 - Foot Care. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>. Accessed 10/26/2022.
2. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (70.2.1). <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=171>. Accessed 10/26/2022.
3. Centers for Medicare & Medicaid Services. Noridian: Foot Care for Patients with Chronic Disease. <https://med.noridianmedicare.com/web/jfb/specialties/podiatry/foot-care-for-patients-with-chronic-disease>. Accessed 10/26/2022.
4. Centers for Medicare & Medicaid Services. Noridian LCA: Coverage of Foot Care Services (A52918). <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52918>. Accessed 10/26/2022.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2023	New medical policy (previously a coding policy) (converted to new policy template 2/2023).
12/2023	Annual review, no change to criteria
12/2024	Annual review, no change to criteria (9/11/2025: Replaced L38904 with L38902 due to Noridian JF consolidation with JE LCD policies) (11/11/2025: Replaced A57957 with A57954 due to Noridian JF consolidation with JE LCD policies)
1/2026	Annual review, no change to criteria. Updated diagnosis code configuration to align with Noridian LCA 10/2025 updates