Medicare Medical Policy

Foot Care Guidelines

MEDICARE MEDICAL POLICY NUMBER: 369

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Next Annual Review: 11/2026

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

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

Service	Medicare Guidelines

Foot Care	Applicable references related to foot care services include the following:
	
	• 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
	  ○ G. 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)

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

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).

MEDICARE AND FOOT CARE SERVICES

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 the following:

1. **Foot care services rendered as a necessary and integral part of otherwise covered services.**
2. **Treatment of warts on the foot.**
3. **Foot care services rendered to individuals with a systemic condition.** This is when foot care services may pose a hazard when performed by a nonprofessional person on patients with such systemic conditions.
4. **Treatment of mycotic nails:** Aside from individuals with a systemic condition noted above, the treatment of mycotic nails may also be eligible for coverage in the *absence* of a systemic condition in one of the following circumstances:

    - The treatment of mycotic nails for an **ambulatory** patient is covered only 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, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.
- The treatment of mycotic nails for a **nonambulatory** patient is covered only when the physician attending the patient's mycotic condition documents that:
    - there is clinical evidence of mycosis of the toenail, and
    - the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

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 <u>not</u> 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.

Medicare expects relatively few claims for routine-type foot care to be 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

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

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

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)[5], indicates HCPCS code S0390 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, 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 the 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 *(CMS-assigned Status "I" code – See "Billing Guidelines")*

***Coding Notes:**

- The code list above 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. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- 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. 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 9/26/2025.
2. Centers for Medicare and Medicaid Services (CMS). 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 9/26/2025.
3. Noridian web page for *Foot Care for Patients with Chronic Disease*; Last Updated: 2/8/2021. https://med.noridianmedicare.com/web/jfb/specialties/podiatry/foot-care-for-patients-with-chronic-disease. Accessed 9/26/2025.
4. Noridian LCA: Coverage of Foot Care Services (A52918). https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52918. Accessed 9/26/2025.
5. CMS. Medicare Physician Fee Schedule (PFS) Relative Value Files. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files. Accessed 9/26/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2023	New Medicare Advantage medical policy (previously a coding policy) (converted to new format 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. Update diagnosis code configuration to align with Noridian 10/2025 LCA updates