HEALTH CHOICE GENERATIONS HMO SNP
PODIATRY SERVICES
FACT SHEET – 2018

The purpose of this document is to detail the difference between medical and supplemental podiatry services and the billing required for payment.

HELPFUL CONTACTS

MEMBER SERVICES/ELIGIBILITY

Phone (800) 656-8991 Fax (480) 784-2933

CONDITIONS THAT MIGHT JUSTIFY COVERAGE

The presence of a systemic condition, such as metabolic, neurologic, or peripheral vascular disease, may require specialized foot care by a professional that, in the absence of such condition(s), would be considered routine (and, therefore, excluded from coverage). Accordingly, routine foot care may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the patient's legs or feet. In these instances, certain foot care procedures that are otherwise considered routine (e.g. cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a non-professional on patients with such systemic conditions. The following metabolic neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that may justify coverage for routine foot care.

Billing/Coding requirements:

MEDICALLY NECESSARY TREATMENT (NON SUPPLEMENTAL):

Submit CPT/HCPCS with modifier "Q"
Prior Authorization is required for CPT/HCPCS codes with Q modifier:
11055, 11056, 11057, 11719, 11720, 11721 or G0127

"Q" Modifiers (Q7, Q8, and Q9) are utilized to denote Class A (Q7), Class B (Q8) and Class C (Q9) findings.

SUPPLEMENTAL BENEFIT (NOT MEDICALLY NECESSARY):

Submit CPT/HCPCS without modifier "Q"
Prior Authorization is NOT required for CPT/HCPCS codes without Q modifier:
11055, 11056, 11057, 11719, 11720, 11721 or G0127

Key Differences Between Medicare covered and Supplemental		
Topic	**Medicare-covered**	**Supplemental**
Covered Services	Medicare Part B (Medical Insurance) covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, and heel spurs). Medicare also covers an evaluation (examination and treatment) of the feet no more often than every six months for beneficiaries with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as s/he has not seen a foot care specialist for some other reason in the interim. The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to foot care coverage.	Four routine care visits per year (one per quarter). This includes: • 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.
Non-Covered Services, except under limited conditions/ situations	Part B generally doesn't cover routine foot care, except for the following conditions or situations: • Necessary and integral part of otherwise covered services or diagnosis and treatment of ulcers, wounds or infections or trimming or cutting nails to be fitted with a cast following a fracture (if the cast is a separately billable service) • Presence of systemic conditions or metabolic, neurologic or vascular conditions that may require scrupulous foot care by a professional • Treatment of warts on foot or treatment of warts, including plantar warts, on the foot is covered to the same extent as services provided for treatment of warts located elsewhere on the body • Mycotic Nails: in the absence of a systemic condition, treatment of mycotic nails may be covered, only when the following criteria are met: Ambulatory patient • Clinical evidence of mycosis of the toenail AND • Patient has marked limitation of ambulation, pain or secondary infection resulting from thickening and dystrophy of the infected toenail plate Non-ambulatory patient- Clinical evidence of mycosis of the toenail AND - Patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate	None
Required criteria	• When submitting claims for services furnished to members who have complicating conditions, the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim, along with the approximate date that the beneficiary was last seen by the indicated physician (when active care is required). • Carefully document any convincing evidence that shows non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition, such as diabetes, does not of itself indicate the severity of the condition.	None

Key Differences Between Medicare covered and Supplemental		
Topic	**Medicare-covered**	**Supplemental**
Coverage Guidelines	• Medicare will cover 11720 and/or 11721 mycotic nail debridement no more often than every 60 days. • Medicare will cover no more than six 11720 and/or 11721 sessions per patient per 12 months absent medical review of patient records demonstrating medical necessity for the procedure. Medicare will not cover 11721 in the absence of a routine foot care exception qualifying condition absent medical review of patient records demonstrating medical necessity for the procedure.	None
Coding Guidelines	**Hyperkeratotic Lesions Coding Criteria** Procedure Code 11055, 11056, or 11057 will be included in the Medicare covered foot care service code (8101) when billed with a diagnosis **Non dystrophic Nails Coding Criteria** Procedure Code 11719 will be included in the Medicare covered foot care service code (8101) when billed with a diagnosis from the Diagnosis **Dystrophic Nails Coding Criteria** Procedure Code G0127 will be included in the Medicare covered foot care service code (8101) when billed with a diagnosis from the Diagnosis List **Debridement of Nail Coding Criteria** Procedure Code 11720 or 11721 will be included in the Medicare covered foot care service code (8101) when billed with a diagnosis from the Diagnosis List. • Modifier usage –Q7 - One Class A finding –Q8 - Two Class B findings –Q9 - One Class B and 2 Class C findings	
Prior Authorization	• Authorization required.	No authorization required.
Costs	• $0 if QMB; 20% of the Medicare-approved amount if non-QMB	No cost share.

Documentation Requirements

It is expected providers retain or have access to appropriate documentation when requested to support coverage. “Q” Modifiers (Q7, Q8, and Q9) are utilized to denote Class A (Q7), Class B (Q8) and Class C (Q9) findings. These modifiers may be used with procedure codes 11055, 11056, 11057, 11719, 11720, 11721 or G0127. Submitting claims using Q7, Q8, or Q9 modifiers indicates the findings related to the patient’s condition, for additional details regarding documentation requirements: https://med.noridianmedicare.com/web/jfb/specialties/podiatry/documentation-requirements

CPT/HCPCS Codes

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Medicare Covered CPT/HCPCS	Description	Frequency limitations
11055 (with Q modifier)	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion	As medically necessary
11056 (with Q modifier)	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); 2 to 4 lesions	As medically necessary
11057 (with Q modifier)	Paring or cutting of benign hypereratotic lesion (e.g., corn or callus); more than 4 lesions	As medically necessary
11719 (with Q modifier)	Trimming of non-dystrophic nails, any number	As medically necessary
11720 (with Q modifier)	Debridement of nail(s) by any method(s); 1 to 5	As medically necessary
11721 (with Q modifier)	Debridement of nail(s) by any method(s); 6 or more	As medically necessary
G0127 (with Q modifier)	Trimming of dystrophic nails, any number	As medically necessary
Supplemental Plan-Covered CPT/HCPCS	**Description**	**Frequency limitations**
11055 (without modifier)	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion	No more than once per 3 months
11056 (without modifier)	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); 2 to 4 lesions	No more than once per 3 months
11057 (without modifier)	Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than 4 lesions	No more than once per 3 months
11719 (without modifier)	Trimming of non-dystrophic nails, any number	No more than once per 3 months
11720 (without modifier)	Debridement of nail(s) by any method(s); 1 to 5	No more than once per 3 months
11721 (without modifier)	Debridement of nail(s) by any method(s); 6 or more	No more than once per 3 months
G0127 (without modifier)	Trimming of dystrophic nails, any number	No more than once per 3 months