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1.0 Description of the Procedure, Product or 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/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

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, refer to **Subsection 2.2** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedures, product, or service is 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;
- b. the procedures, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedures, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific 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 and indicative of severe peripheral involvement 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.

Medically necessary routine foot care, when provided by podiatrists, is covered for specific diagnoses only. Refer to Clinical Coverage Policy #1C-1, *Podiatry Services* Attachment A Section B for an approved list of diagnosis codes.

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 Procedure, Product or 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, refer to **Subsection 2.2** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are 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, product, or service unnecessarily duplicates another provider's procedure; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

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, refer to **Subsection 2.2** 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

- a. This policy applies to podiatrists, physicians and nurse practitioners.
- b. To be eligible to bill for procedures, products, and services related to this policy, providers shall
 - a. meet Medicaid's qualifications for participation;
 - b. be currently enrolled with N.C. Medicaid; and
 - c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

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, refer to **Subsection 2.2** of this policy.

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

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).
12/1/10	Section 1.0	Added standard DMA policy language
12/1/10	Section 3.0	Added standard DMA policy language
12/1/10	Subsection 3.1	Added standard DMA policy language and deleted "the procedures, are medically necessary"
12/1/10	Subsection 3.2	Changed heading from Medical Necessity to Specific Criteria. Added the wording to (b) and indicative of severe peripheral involvement. Added Medically necessary routine foot care, when provided by podiatrists, is covered for specific diagnoses only. Refer to Attachment A Section B Diagnosis Codes for an approved list of diagnosis codes.
12/1/10	Section 4.0	Added standard DMA policy language
12/1/10	Subsection 4.2	Changed Routine Foot Care to Specific Criteria
12/1/10	Section 5.0	Added standard DMA policy language
12/1/10	Section 6.0	Added "a. This policy applies to podiatrists, physicians and nurse practitioners. Added standard DMA policy language"
12/1/10	Section 7.0	Added EPSDT Language Added standard DMA policy language
12/1/10	Attachment A	Section A Claim Type, Section B Diagnosis Codes Added Professional (CMS-1500/837 P transaction) and Institutional (UB_04/837I transaction). Added Refer to Clinical Coverage Policy # 1C-1 Podiatry Services Attachment A Section B for approved list of diagnosis codes. Section E: Billing Units Section F: Place of Service Section G: Co-payments Updated Medicaid billing guide web address Section H: Reimbursement

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

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

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.

Refer to Clinical Coverage Policy #1C-1, *Podiatry Services* Attachment A Section B for approved list of diagnosis codes when this service is provided by a Podiatrist.

C. Procedure Code(s)

The relevant procedure codes are as follows.

Procedure Code	Description
CPT Procedure Codes	
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
HCPCS Procedure Code	
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. Billing Units

Providers may bill one unit per date of service for the above procedure codes

F. Place of Service

Inpatient, outpatient and office.

G. Co-payments

Medically necessary routine foot care services are subject to 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.dhhs.state.nc.us/dma/basicmed/>

H. Reimbursement

Providers must bill their usual and customary charges.