

Routine Foot Care and Debridement of Nails

L34246

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

LCD Information

Document Information

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LCD Title

Routine Foot Care and Debridement of Nails

Proposed LCD in Comment Period

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N/A

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Revision Effective Date

For services performed on or after 08/07/2025

Revision Ending Date

N/A

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Retirement Date

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Notice Period Start Date

N/A

Notice Period End Date

N/A

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Issue

Issue Description

This LCD outlines limited coverage for this service with specific details under Coverage Indications, Limitations, and/or Medical Necessity.

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act

Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862 (a) (1) (A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862 (a) (13)(C) defines the exclusion for payment of routine foot care services.

Code of Federal Regulations (CFR)

Part 411.15., subpart A addresses general exclusions and exclusion of particular services.

CMS Publications:

CMS Publication 100-2, *Medicare Benefit Policy Manual*, Chapter 15:

290 Foot care services which are exceptions to the Medicare coverage exclusion.

CMS Publication 100-3, *Medicare National Coverage Determination (NCD) Manual* Part 1:

70.2.1 Services provided for diagnosis and treatment of diabetic peripheral neuropathy.

CMS Publication 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 5:

National Correct Coding Initiative.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

The Medicare program generally does not cover routine foot care. However, this determination outlines the specific conditions for which coverage may be present.

The following services are considered to be components of routine foot care, regardless of the provider rendering the service:

- Cutting or removal of corns and calluses;
- Clipping, trimming, or debridement of nails, including debridement of mycotic nails;
- Shaving, paring, cutting or removal of keratoma, tyloma, and heloma;
- Non-definitive simple, palliative treatments like shaving or paring of plantar warts which do not require thermal or chemical cautery and curettage;
- Other hygienic and preventive maintenance care in the realm of self care, such as cleaning and soaking the feet and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients;
- Any services performed in the absence of localized illness, injury, or symptoms involving the foot.

Indications:

While the Medicare program generally excludes routine foot care services from coverage, there are specific indications or exceptions under which there are program benefits.

Medicare payment may be made for routine foot care when the patient has a systemic disease, such as metabolic, neurologic, or peripheral vascular disease, of sufficient severity that performance of such services by a nonprofessional person would put the patient at risk (for example, a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization in the patient's legs or feet).

Treatment of warts on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Services normally considered routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.

Treatment of mycotic nails may be covered under the exceptions to the routine foot care exclusion. The class findings, outlined below, or the presence of qualifying systemic illnesses causing a peripheral neuropathy, must be present. Payment may be made for the debridement of a mycotic nail (whether by manual method or by electrical grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit and the physician attending the mycotic condition documents that the following criteria are met:

In the absence of a systemic condition, the following criteria must be met:

- In the case of ambulatory patients there exists:
 - Clinical evidence of mycosis of the toenail, and
 - Marked limitation of ambulation, pain, and/or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.
- In the case of non-ambulatory patients there exists:
 - Clinical evidence of mycosis of the toenail , and
 - The patient suffers from pain and/or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

In addition, procedures for treating toenails are covered for the following:

Onychogryphosis (defined as long-standing thickening, in which typically a curved hooked nail (ram's horn nail) occurs), and there is marked limitation of ambulation, pain, and/or secondary infection where the nail plate is causing symptomatic indentation of or minor laceration of the affected distal toe; and/or

Onychia (defined as a thickening (hypertrophy) of the base of the nail/nail bed) and there is marked limitation of ambulation, pain, and/or secondary infection that causes symptoms.

The following physical and clinical findings, which are indicative of severe peripheral involvement, must be documented and maintained in the patient record, in order for routine foot care services to be reimbursable.

Class A findings

Non-traumatic amputation of foot or integral skeletal portion thereof

Class B findings

Absent posterior tibial pulse

Advanced trophic changes as evidenced by any three of the following:

1. hair growth (decrease or increase)
2. nail changes (thickening)
3. pigmentary changes (discoloring)
4. skin texture (thin, shiny)
5. skin color (rubor or redness);and

Absent dorsalis pedis pulse

Class C findings

Claudication

Temperature changes (e.g., cold feet)

Edema

Paresthesias (abnormal spontaneous sensations in the feet)

Burning

The presumption of coverage may be applied when the physician rendering the routine foot care has identified:

1. A Class A finding

2. Two of the Class B findings; or
3. One Class B and two Class C findings.

Note: Benefits for routine foot care are also available for patients with peripheral neuropathy involving the feet, but without the vascular impairment outlined in Class B findings. The neuropathy should be of such severity that care by a non-professional person would put the patient at risk. If the patient has evidence of neuropathy but no vascular impairment, the use of class findings modifiers is not necessary. This condition would be represented by the appropriate ICD-10-CM code being included on the claim.

Limitations:

When the patient's condition is designated by an ICD-10-CM code that indicates the routine foot care was done based on the patient having a complicating disease, the procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service or if the patient had come under a physician's care shortly after the services were furnished.

The global surgery rules will apply to routine foot care procedure codes. As a result, an E&M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E&M service is a significant separately identifiable service, indicated by the use of modifier 25, and documented by medical records.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. CGS Administrators, LL is not responsible for the continuing viability of Web site addresses listed below.

Copyright 2001, Physicians' Current Procedural Terminology, American Medical Association

Copyright Medicode's HCPCS 2000 and 2002

Empire Medicare Services New York and New Jersey Medical Directors.

Other Carrier Policies (Connecticut-Policy Number 94004A V1.2 revised January 13, 1998, Florida-Local Medical Review Policy revised August 14, 1998, and New York State Local Medical Review Policy-Empire/GHI/UMD-Policy Number FC001E02 revised February 25, 2000)

Bibliography

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
08/07/2025	R18	R19 Revision Effective: 08/07/2025 Revision Explanation: Annual Review, no changes were made. <i>07/29/2025 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Other (Annual Review)
08/08/2024	R17	R18 Revision Effective: 08/08/2024 Revision Explanation: Annual Review, no changes were made. <i>08/08/2024-At this time 21st Century Cures Act will apply to new and revised LCDs that</i>	Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	
08/03/2023	R16	R17 Revision Effective: 08/03/2023 Revision Explanation: Annual Review, no changes were made. <i>08/03/2023-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Other (Annual Review)
08/04/2022	R15	R16 Revision Effective: 08/04/2022 Revision Explanation: Annual Review, no changes were made <i>07/26/2022-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Other (Annual Review)
07/29/2021	R14	R15 Revision Effective: 07/29/2021 Revision Explanation: Annual Review, no changes were made <i>07/23/2021-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage</i>	Other (Annual Review)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	
11/28/2019	R13	R14 Revision Effective: n/a Revision Explanation: Annual Review, no changes made <i>07/30/2020-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Other (Annual Review, no changes made)
11/28/2019	R12	R13 Revision Effective: 11/28/2019 Revision Explanation: Removed other comments from coverage and indications section and information in associated documents section was removed and placed in the billing and coding article. <i>11/20/2019-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Provider Education/Guidance
10/03/2019	R11	R12 Revision Effective: 10/03/2019 Revision Explanation: During the code migration information for the indications and limitations for routine foot care was accidentally remove from the coverage and indication section. This information as been added back the section.	Typographical Error

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>10/09/2019-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	
10/01/2018	R10	R11 Revision Effective: 10/03/2019 Revision Explanation: Removed billing and coding based on CR10901. Converted to new policy template that no longer includes coding section based on CR 10901. Supplemental article is being retired and replaced with new article A57193. <i>09/18/2018-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	• Revisions Due To Code Removal
10/01/2018	R9	Annual Review, no changes made.	• Other (Annual Review)
10/01/2018	R8	R9 Revision Effective: 10/01/2018 Revision Explanation: New code E75.26 was added to group 1 and 3 from 2019 ICD-10 annual review. <i>09/18/2018-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and</i>	• Revisions Due To ICD-10-CM Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	
10/01/2017	R7	R8 Revision Effective: N/A Revision Explanation: Annual review no changes made. <i>07/30/2018-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	Other (Annual review)
10/01/2017	R6	R7 Revision Effective: 10/01/2017 Revision Explanation: During ICD-10 annual review E85.8 was deleted and replaced with E85.81, E85.82, and E85.89 in groups 1 and 3. <i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i> R6 Revision Effective: N/A Revision Explanation: Annual review no changes made.	Revisions Due To ICD-10-CM Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		<i>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i>	

10/01/2016	R5	R5 Revision Effective: 10/01/2016 Revision Explanation: During annual ICD-10 update codes E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359 were deleted and replaced with the following codes: E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E08.37X1, E08.37X2, E08.37X3, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E09.37X1, E09.37X2, E09.37X3, E10.3211, E10.3212, E10.3213, E10.3291,	Revisions Due To ICD-10-CM Code Changes
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Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, e10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E10.37X1, E10.37X2, E10.37X3, E11.3211, e11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, e11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E11.37X1, E11.37X2, E11.37X3, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, e13.3413, E13.3491, E13.3492, e13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, e13.3592, E13.3593, E13.37X1, E13.37X2, E13.37X3	
10/01/2015	R4	R4 Revision Effective: N/A Revision Explanation: Annual review corrected formatting listing class finding to move the heading for Class C from end of class B findings to over the list for class C.	Other (annual review and formatting)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
10/01/2015	R3	R3 Revision Effective:10/01/2015 Revision Explanation: Removed ICD-9 code left in text in error as well as L60.8 and L62 since it was removed from group 2.	• Typographical Error
10/01/2015	R2	R2 Revision Effective:10/01/2015 Revision Explanation: In indications section L60.0 should have been L60.2.	• Typographical Error
10/01/2015	R1	R1 Revision Effective:10/01/2015 Revision Explanation: In group 2 ICD-10 code L60.8 and L62 were included in error.	• Typographical Error

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

[A57193 - Billing and Coding: Routine Foot Care and Debridement of Nails \(Future\)](#) 

Related National Coverage Documents

NCDs

[70.2.1 - Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation \(aka Diabetic Peripheral Neuropathy\)](#) 

Public Versions

Updated On	Effective Dates	Status	
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Updated On	Effective Dates	Status	
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Keywords

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