

Routine Foot Care

L35138

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Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
Novitas Solutions, Inc.	A and B MAC	04111 - MAC A	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04112 - MAC B	J - H	Colorado
Novitas Solutions, Inc.	A and B MAC	04211 - MAC A	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04212 - MAC B	J - H	New Mexico
Novitas Solutions, Inc.	A and B MAC	04311 - MAC A	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04312 - MAC B	J - H	Oklahoma
Novitas Solutions, Inc.	A and B MAC	04411 - MAC A	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04412 - MAC B	J - H	Texas
Novitas Solutions, Inc.	A and B MAC	04911 - MAC A	J - H	Colorado New Mexico Oklahoma Texas
Novitas Solutions, Inc.	A and B MAC	07101 - MAC A	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07102 - MAC B	J - H	Arkansas
Novitas Solutions, Inc.	A and B MAC	07201 - MAC A	J - H	Louisiana
Novitas Solutions, Inc.	A and B MAC	07202 - MAC B	J - H	Louisiana

Contractor Name	Contract Type	Contract Number	Jurisdiction	States
Novitas Solutions, Inc.	A and B MAC	07301 - MAC A	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	07302 - MAC B	J - H	Mississippi
Novitas Solutions, Inc.	A and B MAC	12101 - MAC A	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12102 - MAC B	J - L	Delaware
Novitas Solutions, Inc.	A and B MAC	12201 - MAC A	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12202 - MAC B	J - L	District of Columbia
Novitas Solutions, Inc.	A and B MAC	12301 - MAC A	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12302 - MAC B	J - L	Maryland
Novitas Solutions, Inc.	A and B MAC	12401 - MAC A	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12402 - MAC B	J - L	New Jersey
Novitas Solutions, Inc.	A and B MAC	12501 - MAC A	J - L	Pennsylvania
Novitas Solutions, Inc.	A and B MAC	12502 - MAC B	J - L	Pennsylvania
Novitas Solutions, Inc.	A and B MAC	12901 - MAC A	J - L	Delaware District of Columbia Maryland New Jersey Pennsylvania

LCD Information

Document Information

LCD ID

L35138

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LCD Title

Routine Foot Care

Proposed LCD in Comment Period

N/A

Source Proposed LCD

N/A

Original Effective Date

For services performed on or after 10/01/2015

Revision Effective Date

For services performed on or after 10/17/2019

Revision Ending Date

N/A

Retirement Date

N/A

Notice Period Start Date

N/A

Notice Period End Date

N/A

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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for routine foot care. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for routine foot care and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

IOM Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 Foot Care
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 1, Section 70.2.1 Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy).

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
- Title XVIII of the Social Security Act, Section 1862(a)(13)(C) states that no payment shall be made where such expenses are for routine foot care.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

The Medicare program generally does not cover routine foot care. However, CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 Foot Care outlines complete coverage details and the specific conditions for which coverage may be present.

Indications

Please refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 B 2 Routine Foot Care for a list of services that are generally considered components of routine foot care.

In addition to those services listed in the above manual, 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
- 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;

While the Medicare program generally excludes routine foot care services from coverage, there are specific indications or exceptions under which there are program benefits. Please refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 C for information on exceptions to routine foot care exclusion.

Note: Information on the potential coverage and billing for those diabetic patients with severe peripheral neuropathy involving the feet, but without vascular impairment (LOPS), may be found at: *Medicare National Coverage Determinations Manual*-Pub. 100-03, Chapter 1, Section 70.2.1 and *Medicare Claims Processing Manual*-Pub. 100-04, Chapter 32, Sections 80-80.8.

CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 D lists systemic

conditions that may justify coverage for routine foot care. In addition to those listed in the manual, the following conditions represent systemic conditions that may result in the need for routine foot care:

- Amyotrophic Lateral Sclerosis (ALS)
- Arteritis of the feet
- Chronic indurated cellulitis
- Chronic venous insufficiency
- Intractable edema-secondary to a specific disease (e.g., congestive heart failure, kidney disease, hypothyroidism)
- Lymphedema-secondary to a specific disease (e.g., Milroy's disease, malignancy)
- Peripheral vascular disease
- Raynaud's disease

Claims indicating other diagnoses not specified above will be denied unless the medical record documentation is submitted with the claim.

Limitations

1. When the patient's condition is designated by an ICD-10-CM code with an asterisk (*) (see ICD-10-CM Codes in the Local Coverage Article: Billing and Coding: Routine Foot Care [A52996]), routine foot care procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) or NPP 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 or NPPS care shortly after the services were furnished.
2. Routine foot care should not be paid in the absence of convincing evidence that non-professional performance of the service would be hazardous for the patient because of an underlying systemic disease.
3. Evaluation and management (E/M) services for any of the conditions defined as routine foot care will be considered ineligible for reimbursement, with the exception of the initial E/M service performed to diagnose the patient's condition.
4. Evaluation and management (E/M) services provided on the same day as routine foot care by the same doctor for the same condition are not eligible for payment except if it is the initial E/M service performed to diagnose the patient's condition or if the E/M service is a significant separately identifiable service indicated by the use of modifier 25, and documented by medical records.
5. Additionally, whirlpool treatment performed prior to routine foot care to soften the nails or skin is not eligible for separate reimbursement.

This LCD imposes frequency limitations. For frequency limitations, please refer to the Utilization Guidelines section below.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules. Please refer to the Local Coverage Article: Billing and Coding: Routine Foot Care (A52996) for applicable CPT and diagnosis codes.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

Refer to the Local Coverage Article Billing and Coding: Routine Foot Care (A52996) for all coding information.

Documentation Guidelines

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service[s]). The record must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record should support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The Medical record documentation must support the medical necessity of the services as stated in this policy.
5. Routine foot care services performed more often than every 60 days will be denied unless documentation is submitted with the claim to substantiate the increased frequency. This evidence should include office records or physician notes and diagnoses characterizing the patient's physical status as being of such an acute or severe nature that more frequent services are appropriate.
6. For foot-care services covered by virtue of the presence of a qualifying, covered systemic disease (asterisked and non-asterisked elsewhere in the Internet-Only Manual, the LCD and the corresponding Local Coverage Article). Medicare expects the clinical record to contain a sufficiently detailed clinical description of the feet to provide convincing evidence that non-professional performance of the service is hazardous to the patient. For this purpose, documentation limited to a simple listing of class findings is insufficient. Medicare does not require the detailed clinical description to be reported at each instance of routine foot care when an earlier record continues to accurately describe the patient's condition at the time of the foot care. In such cases, the record should reference the location (i.e., date of service) in the record of the previously recorded detailed information. Further, detailed information so referenced should be made available to Medicare upon request.

The patient's record must include the following:

- Location of each lesion treated.
- identification (by number or name) and description of all nails treated.

7. To distinguish debridement from trimming or clipping, Medicare expects records to contain some description of the debridement procedure beyond simple statements such as "nail(s) debrided."
8. For routine foot care and debridement of multiple symptomatic nails to people who have a qualifying systemic condition, the records should demonstrate the necessity of each service considering the patient's usual activities.
9. Documentation of foot-care services to residents of nursing homes not performed solely at the request of the patient or patient's family/conservator must include a current nursing facility order (dated and signed with date of signature) for routine foot-care service issued by the patient's supervising physician that describes the specific service necessary. Such orders must meet the following requirements:
 - The order must be dated and must have been issued by the supervising physician prior to foot-care services being rendered.
 - Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within a reasonable period of time following the issuance of the order.
 - The order must be for medically necessary services to address a specific patient complaint or physical finding.
 - Routinely issued or "standing" facility orders for routine foot-care services and orders for non-specific foot-care services that do not meet the above requirements are insufficient.
 - Documentation of foot-care services to residents of nursing homes performed solely at the request of the patient or patient's family/conservator should indicate if the request was from the patient or the patient's family/conservator. When the request is from someone other than the patient the documentation should identify the requesting person's relationship to the patient.
10. There must be adequate documentation to demonstrate the need for routine foot care services as outlined in this determination. This documentation may be office records, physician notes or diagnoses characterizing the patient's physical status as being of such severity to meet the criteria for exceptions to the Medicare routine foot care exclusion.

Appendices

N/A

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

The frequency of routine foot care varies among patients. Medicare will cover routine foot care as often as is medically necessary but no more often than every 60 days.

Notice: This LCD imposes utilization guideline limitations. Despite Medicare's allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical records. Medicare expects that patients will not routinely require the maximum allowable

number of services.

Sources of Information

JH LCD L32669, Routine Foot Care

Contractor is not responsible for the continued viability of websites listed.

Other Contractor's Policies

Novitas Solutions Contractor Medical Directors

Bibliography

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
10/17/2019	R7	LCD revised and published on 10/17/2019. Consistent with CMS Change Request 10901, the entire coding section has been removed from the LCD and placed into the related Billing and Coding Article, A52996. All CPT codes and coding information within the text of the LCD has been placed in the Billing and Coding Article.	Other (CMS Change Request 10901)
04/11/2019	R6	LCD revised and published on 04/11/2019. The IOM Citations section was revised to add applicable manual references and to remove the reference to NCCI since coding and billing information has been moved to the companion article. All manual language has been removed from the LCD with references to the applicable manuals, consistent with CMS Change Request (CR) 10901. All billing and coding related information has been moved to the Local Coverage Article Billing and Coding: Routine Foot Care (A52996).	Other (Change in LCD process per CR 10901)
12/14/2017	R5	LCD revised and published on 12/14/2017 to correct a formatting issue with the "Absent dorsalis pedis	Other (Inquiry)

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		pulse" bullet in the Class B findings, to correct the wording with hair growth in the Class B findings to reflect absence, and to change the CPT code descriptors to the short descriptors. 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; therefore, not all the fields included on the LCD are applicable as noted in this policy.	
10/01/2017	R4	LCD revised and published on 10/05/2017 effective for dates of service on and after 10/01/2017 to reflect the Annual ICD-10-CM Code Updates. The following ICD-10 code(s) have been deleted from Group 1 codes: E85.8. The following ICD-10 code(s) have been added to Group 1 codes: G12.25, E11.10*, E11.11*, E85.81, E85.82, E85.89. 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; therefore, not all the fields included on the LCD are applicable as noted in this policy.	Revisions Due To ICD-10-CM Code Changes
10/01/2016	R3	LCD revised and published on 09/29/2016 effective for dates of service on and after 10/01/2016 to reflect the ICD-10 Annual Code Updates. The following ICD-10 codes have been deleted and therefore removed from the Group 1 list of ICD-10 codes in the LCD: 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 and E13.359. The following ICD-10 codes	Revisions Due To ICD-10-CM Code Changes

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		have been added to Group 1 diagnosis 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, 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, 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, and E13.37X3. Please note, the codes added to Group 1 diagnosis codes are all included within the Group 1: Medical Necessity ICD-10 Codes Asterisk	

Revision History Date	Revision History Number	Revision History Explanation	Reasons for Change
		Explanation. The asterisk symbol (*) was not placed in the revision history. The following ICD-10 codes have had a descriptor change: O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, and O24.13.	
10/01/2015	R2	LCD revised on 12/09/2014 to include missing Bill type codes (71x, 73x, 75x, 77x) and corrected any typographical errors.	• Typographical Error
10/01/2015	R1	LCD revised on 10/09/2014 and posted on 12/04/2014 to create uniform LCD with other MAC Jurisdiction.	• Creation of Uniform LCDs With Other MAC Jurisdiction

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

[A52996 - Billing and Coding: Routine Foot Care](#) 

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	
10/11/2019	10/17/2019 - N/A	Currently in Effect	You are here

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Keywords

N/A