https://www.novitas-solutions.com/policy/jh/l32669-r5.html

LCD L32669 - Routine Foot CarePrint

Contractor Information

Contractor Name:

Novitas Solutions, Inc.

Contractor Number(s):

04911, 07101, 07102, 07201, 07202, 07301, 07302, 04111, 04112, 04211, 04212, 04311, 04312, 04411, 04412

Contractor Type:

MAC Part A & B

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LCD Information

Document Information

LCD ID Number

L32669

LCD Title

Routine Foot Care

Contractor's Determination Number

L32669

AMA CPT/ADA CDT Copyright Statement

Primary Geographic Jurisdiction

Arkansas, Louisiana, Mississippi, Colorado, Texas, Oklahoma, New Mexico

Oversight Region

Central Office

Original Determination Effective Date

For services performed on or after 08/13/2012

Original Determination Ending Date

N/A

Revision Effective Date

For services performed on or after 01/01/2013

CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determination (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 regarding Routine Foot Care are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 290.

Medicare National Coverage Determinations Manual – Pub. 100-03, Part 1, Section 70.2.1.

Correct Coding Initiative – Medicare Contractor Beneficiary and Provider Communications Manual – Pub. 100-09, Chapter 5.

Social Security Act (Title XVIII) Standard References, Sections:

1862(a)(1)(A) Medically Reasonable & Necessary.

1862(a)(1)(D) Investigational or Experimental.

1862(a)(7) Screening (Routine Physical Checkups).

1862(a)(13)(A) Treatment of Flat Foot.

1862(a)(13)(B) Treatment of Subluxation of the Foot.

1862(a)(13)(C) Routine Foot Care.

1833(e) Incomplete Claim.

Jurisdiction “H” Notice:

Jurisdiction “H” comprises the states of Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Oklahoma, and Texas. Novitas is responsible for claims payment and Local Coverage Determination (LCD) development for this jurisdiction. This LCD was created as a part of the legacy transition (8/13/2012 – 11/19/2012); and, is a consolidation of the previous legacy contractors’ policies. Coverage of each LCD begins when the state/contract number combination officially is integrated into the Jurisdiction. On the CMS MCD, this date is known as either the Original Effective Date or the Revision Effective Date. The following table details the official effective dates for each state/contract number combination.

ST	Legacy A	
Contractor		
&		
Contract Number	Legacy B	
Contractor		
&		
Contract Number	J "H" MAC A	
Contractor		
&		
Contract Number	J "H" MAC B	
Contractor		
&		
Contract Number	J "H"	
Effective		
Date		
AR	PBSI: 00520 (J7)	Novitas: 07102 08/13/12
LA	PBSI: 00528 (J7)	Novitas: 07202 08/13/12
AR	PBSI: 00020 (J7)	Novitas: 07101 08/20/12
LA	PBSI: 00233 (J7)	Novitas: 07201 08/20/12
MS	PBSI: 00233 (J7)	Novitas: 07301 08/20/12
MS	Cahaba: 00512 (J7)	Novitas: 07302 10/22/12
J 4		
States	Trailblazer: 04901	Novitas: 04911 10/29/12
CO	Trailblazer: 04101	Novitas: 04111 10/29/12
NM	Trailblazer: 04201	Novitas: 04211 10/29/12

OK	Trailblazer: 04301	Novitas: 04311	10/29/12
TX	Trailblazer: 04401	Novitas: 04411	10/29/12
CO	Trailblazer: 04102	Novitas: 04112	11/19/12
NM	Trailblazer: 04202	Novitas: 04212	11/19/12
OK	Trailblazer: 04302	Novitas: 04312	11/19/12
TX	Trailblazer: 04402	Novitas: 04412	11/19/12

Indications and Limitations of Coverage 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.

This LCD does not supercede national policy for Medicare coverage of routine foot-care services found in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 290. Pertinent parts of that national policy are referenced in this LCD

From the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 290:

Excluded Foot-Care Services

The following foot-care services are excluded from Medicare coverage:

Treatment of Subluxation of Foot

National

Supportive Devices for Feet

National

Routine Foot Care

National

Treatment of Flat Foot

National

Exceptions to Routine Foot-Care Exclusions

Payment may be made as an exception to the routine foot-care exclusion if one of the following conditions is met. In addition, as for any other Medicare-covered service, the foot-care service must be reasonable and necessary for the treatment of an illness or injury or to improve the functioning of a malformed body member.

Necessary and Integral Part of Otherwise Covered Services

National

Treatment of Warts on Foot

National

Presence of Systemic Condition

National

Mycotic Nails

Routine foot-care services to patients whose condition is not codifiable with a Q modifier describing the class findings, and which are not covered under the provisions of the following paragraph regarding foot-care services for patients with diabetic sensory neuropathy and Loss of Protective Sensation (LOPS), are excluded from Medicare coverage (see “LCD Individual Consideration” paragraph below).

Services that are not codifiable using a Q modifier are not payable by Medicare except in those cases for which the review of medical records demonstrates that the patient’s condition meets exception criteria to the exclusion from Medicare payment for routine foot care. Individual consideration of such claims should be requested during the claim redetermination process.

Foot-Care Services for Patients with Diabetic Sensory Neuropathy and LOPS

The Medicare National Coverage Determinations Manual, Pub. 100-03, Part 1, Section 70.2.1, describes national policy regarding Medicare guidelines for services provided for the diagnosis and treatment of diabetic sensory neuropathy with LOPS.

HCPCS codes G0245, G0246 and G0247 have been developed for reporting these physician services under this coverage. Codes G0245 and G0246 have been revised to describe them more accurately as E/M services. The new codes are described as:

G0245 Initial physician evaluation of a diabetic patient with diabetic sensory neuropathy resulting in LOPS, which must include:

The diagnosis of LOPS.

A patient history.

A physical examination consisting of findings regarding at least the following elements:

Visual inspection of the forefoot, hindfoot and toe web spaces.

Evaluation of protective sensation.

Evaluation of foot structure and biomechanics.

Evaluation of vascular status and skin integrity.

Evaluation and recommendation of footwear.

Patient education.

G0246 Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in LOPS to include at least the following:

A patient history.

A physical examination consisting of findings that includes:

Visual inspection of the forefoot, hindfoot and toe web spaces.

Evaluation of protective sensation.

Evaluation of foot structure and biomechanics.

Evaluation of vascular status and skin integrity.

Evaluation and recommendation of footwear.

Patient education.

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in LOPS to include if present, at least the following:

Local care of superficial wounds.

Debridement of corns and calluses.

Trimming and debridement of nails.

Medicare payment for routine foot-care services to patients with diabetic sensory neuropathy who do not meet the class findings will be limited to the provisions of the coverage in this section of the LCD.

Limitations:

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, 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.

As published in CMS IOM 100-08, Section 13.5.1, to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

Safe and effective.

Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the clinical trials NCD are considered reasonable and necessary).

Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

Furnished in accordance with accepted standards of medical

practice for the diagnosis or treatment of the patient's

condition or to improve the function of a malformed body

member.

Furnished in a setting appropriate to the patient's medical needs

and condition.

Ordered and furnished by qualified personnel.

One that meets, but does not exceed, the patient's medical needs.

At least as beneficial as an existing and available medically

appropriate alternative.

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Coding Information

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
018x	Hospital - Swing Beds
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
071x	Clinic - Rural Health
073x	Clinic - Freestanding
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
077x	Clinic - Federally Qualified Health Center (FQHC)

085x Critical Access Hospital

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Note: The contractor has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS Internet-Only Manual (IOM), Publication 100-04, Claims Processing Manual, for further guidance.

Revenue codes have not been identified for all procedures/services as they can be performed in a number of revenue centers within a hospital, such as emergency room (0450), operating room (0360) or clinic (0510).

99999

Not Applicable

CPT/HCPCS Codes

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

11055	Trim skin lesion
11056	Trim skin lesions 2 to 4
11057	Trim skin lesions over 4
11719	Trim nail(s) any number
G0127	Trim nail(s)
G0245	Initial foot exam pt lops

G0246 Followup eval of foot pt lop

G0247 Routine footcare pt w lops

ICD-9 Codes that Support Medical Necessity

Note: Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

The CPT/HCPCS codes included in this LCD will be subjected to “procedure to diagnosis” editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for CPT/HCPCS codes 11055, 11056, 11057, 11719 and G0127:

Covered for:

030.1*

TUBERCULOID LEPROSY (TYPE T)

042*

HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE

090.1*

EARLY CONGENITAL SYPHILIS LATENT

250.00 - 250.03*

DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.10 - 250.13*

DIABETES WITH KETOACIDOSIS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH KETOACIDOSIS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.20 - 250.23*

DIABETES WITH HYPEROSMOLARITY, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH HYPEROSMOLARITY, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.30 - 250.33*

DIABETES WITH OTHER COMA, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER COMA, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.40 - 250.43*

DIABETES WITH RENAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH RENAL MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.50 - 250.53*

DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.60 - 250.63*

DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.70 - 250.73*

DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.80 - 250.83*

DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

250.90 - 250.93*

DIABETES WITH UNSPECIFIED COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH UNSPECIFIED COMPLICATION, TYPE I [JUVENILE TYPE], UNCONTROLLED

265.2*

PELLAGRA

272.7*

LIPIDOSES

277.30*

AMYLOIDOSIS, UNSPECIFIED

277.39*

OTHER AMYLOIDOSIS

281.0*

PERNICIOUS ANEMIA

340*

MULTIPLE SCLEROSIS

344.00 - 344.04

QUADRIPLEGIA UNSPECIFIED - QUADRIPLEGIA C5-C7 INCOMPLETE

344.09

OTHER QUADRIPLEGIA

344.1

PARAPLEGIA

344.30 - 344.32

MONOPLEGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE

355.0 - 355.6

LESION OF SCIATIC NERVE - LESION OF PLANTAR NERVE

355.71

CAUSALGIA OF LOWER LIMB

355.79

OTHER MONONEURITIS OF LOWER LIMB

355.8 - 355.9

MONONEURITIS OF LOWER LIMB UNSPECIFIED - MONONEURITIS OF UNSPECIFIED SITE

356.0 - 356.4

HEREDITARY PERIPHERAL NEUROPATHY - IDIOPATHIC PROGRESSIVE POLYNEUROPATHY

356.8 - 356.9

OTHER SPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY - UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY

357.0 - 357.1

ACUTE INFECTIVE POLYNEURITIS - POLYNEUROPATHY IN COLLAGEN VASCULAR DISEASE

357.2 - 357.7*

POLYNEUROPATHY IN DIABETES - POLYNEUROPATHY DUE TO OTHER TOXIC AGENTS

357.81 - 357.82

CHRONIC INFLAMMATORY DEMYELINATING POLYNEURITIS - CRITICAL ILLNESS POLYNEUROPATHY

357.9

UNSPECIFIED INFLAMMATORY AND TOXIC NEUROPATHIES

440.20 - 440.24

ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES UNSPECIFIED - ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE

440.29

OTHER ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES

440.30 - 440.32

ATHEROSCLEROSIS OF UNSPECIFIED BYPASS GRAFT OF THE EXTREMITIES - ATHEROSCLEROSIS OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT OF THE EXTREMITIES

440.4

CHRONIC TOTAL OCCLUSION OF ARTERY OF THE EXTREMITIES

443.1

THROMBOANGIITIS OBLITERANS (BUERGER'S DISEASE)

443.9

PERIPHERAL VASCULAR DISEASE UNSPECIFIED

447.9

UNSPECIFIED DISORDERS OF ARTERIES AND ARTERIOLES

451.0*

PHLEBITIS AND THROMBOPHLEBITIS OF SUPERFICIAL VESSELS OF LOWER EXTREMITIES

451.11*

PHLEBITIS AND THROMBOPHLEBITIS OF FEMORAL VEIN (DEEP) (SUPERFICIAL)

451.19*

PHLEBITIS AND THROMBOPHLEBITIS OF OTHER

451.2*

PHLEBITIS AND THROMBOPHLEBITIS OF LOWER EXTREMITIES UNSPECIFIED

579.0 - 579.1*

CELIAC DISEASE - TROPICAL SPRUE

585.4 - 585.6*

CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE) - END STAGE RENAL DISEASE

Note: (See bullets below) For Medicare to cover routine foot care for patients with diagnoses: 250.00–250.03, 250.10–250.13, 250.20–250.23, 250.30–250.33, 250.40–250.43, 250.50–250.53, 250.60–250.63, 250.70–250.73, 250.80–250.83, 250.90–250.93, 265.2, 281.0, 340, 357.2–357.7, 451.0, 451.11, 451.19, 451.2, 579.0–579.1 and 585.4–585.6.

The patient must be under the active care of an MD or DO to qualify for covered routine foot care.

The patient must have been seen by that physician for the specified condition within six months prior to or six weeks following the foot-care services.

For the purposes of this LCD, the coverage condition of “active care by a physician” clause above may be satisfied when appropriate care has been rendered by a Nurse Practitioner (NP), Physician Assistant (PA) or Clinical Nurse Specialist (CNS) who is licensed by the state to provide such services. References to “MD or DO” or “physician” in regard to the active care clause will include physicians (MDs and DOs), NPs, PAs and CNSs.

Note: Use codes 030.1*, 042*, 090.1* with 357.4 (polyneuropathy in other diseases classified elsewhere).

Note: Use codes 265.2*, 272.7*, 277.30*, 277.39*, 281.0* with 357.4 (polyneuropathy in other diseases classified elsewhere).

Note: Use codes 579.0*–579.1* and 585.4*–585.6* with 357.4 (polyneuropathy in other diseases classified elsewhere).

Medicare is establishing the following limited coverage for CPT/HCPCS codes G0245, G0246 and G0247:

Covered for:

250.60 - 250.63

DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH NEUROLOGICAL MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED

357.2

POLYNEUROPATHY IN DIABETES

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

All diagnoses not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this LCD.

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Other Information

Documentation Requirements

Documentation supporting medical necessity must be legible and available to Medicare upon request.

For foot-care services covered by virtue of the presence of a qualifying covered systemic disease (asterisked and non-asterisked elsewhere in this LCD), 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 repeated 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 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.

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."

For routine foot care and debridement of multiple symptomatic nails to people who have a qualifying systemic condition, the record should demonstrate the necessity of each service considering the patient's usual activities.

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 issuance of the order.

The order must be consistent with the attending physician's overall plan of care.

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 name the person who requested the services and should identify the requesting person’s relationship to the patient.

The following documentation requirements for HCPCS codes G0245, G0246 and G0247 are provided by CMS:

For codes G0245, G0246 and G0247, the medical record must include documentation of performance of all elements listed in the code descriptions.

For code G0245, the patient history should include, but is not limited to, how, when and by whom the diagnosis of LOPS was made, as well as any pertinent present and/or past history regarding the feet).

For code G0246, the patient history should include, at the least, an interval history regarding the feet since the previous evaluation.

For code G0247, the description of routine foot-care services contains similar information as other covered routine foot-care services listed above.

For codes G0245 and G0246, record the educational methods and the identity of the educator.

Appendices

N/A

Utilization Guidelines

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 record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Sources of Information and Basis for Decision

Other Contractor Local Coverage Determinations

“Routine Foot Care/Mycotic Nail Debridement,” TrailBlazer LCD, (00400) L12481, (00900) L12473.

“Treatment of Ulcers and Symptomatic Hyperkeratoses,” Noridian Administrative Services, LLC LCD, (CO) L23770.

“Routine Foot Care,” Noridian Administrative Services, LLC LCD, (CO) L23756.

“Routine Foot Care,” Arkansas BlueCross BlueShield (Pinnacle) LCD, (NM, OK) L11701 and L11826.

Novitas Solutions, Inc. – JH Local Coverage Determination (LCD) Consolidation, Narrative Justification – Most Clinically Appropriate LCD

LCDs Compared:

L30848, Routine Foot Care, TrailBlazer, TX, CO, NM, OK, Indian Health Service, ESRD,SNF, RHC, WPS legacy provider – A/B

CMD Rationale:

TrailBlazer has the only policy. This is a national coverage policy.

TrailBlazer has combined the national coverage decision on Loss of Protective Sensation (LOPS) to the policy. The NCD suggests some diagnoses codes as an example. The Texas policy has specific ICD 9 CM codes associated with it. There is diagnosis to procedure code editing. Frequency parameters are outlined In the National Coverage Decision already. The documentation guidance is important. This is an area that receives a lot of inquiries. The contractor recommends retaining this document.

L30848 is the most clinically appropriate LCD.

Advisory Committee Meeting Notes

N/A

Start Date of Comment Period

N/A

End Date of Comment Period:

N/A

Start Date of Notice Period

06/28/2012

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Revision History

Revision History Number

6

Revision History Explanation

Date Policy # Description

01/01/2013

(Revision History #6)

LCD revised for dates of service on and after 01/01/2013 to reflect the annual CPT/HCPCS code updates. The following code descriptor(s) have been revised: 11719.

11/19/2012

(Revision History #5)

Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 11/19/2012 to add the Novitas Jurisdiction H Part B MAC Contract Numbers 04112, 04212, 04312, and 04412 for Colorado Part B, New Mexico Part B, Oklahoma Part B, Texas Part B, Indian Health Service

(IHS)/Tribal/Urban Indian Providers Part B, and Veterans Affairs (VA) Part B. No other changes were made to this LCD.

10/29/2012

(Revision History #4)

Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 10/29/2012 to add the Novitas Jurisdiction H Part A MAC Contract Numbers 04911, 04111, 04211, 04311, and 04411 for Colorado Part A, New Mexico Part A, Oklahoma Part A, Texas Part A, Indian Health Service (IHS)/Tribal/Urban Indian Providers Part A, and Veterans Affairs (VA) Part A. No other changes were made to this LCD.

10/22/2012

(Revision History #3)

LCD original effective date of 10/22/2012 for Mississippi Part B.

08/20/2012

(Revision History #2)

LCD original effective date of 08/20/2012 for Arkansas Part A, Louisiana Part A and Mississippi Part A.

08/13/2012

(Revision History #1)

LCD original effective date of 08/13/2012 for Arkansas Part B and Louisiana Part B. LCD posted for notice on 06/28/2012.

Reason for Change

HCPCS/ICD9 Descriptor Change

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD

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