Podiatry Payment Policy

Policy

The Plan covers non-routine podiatry services to treat underlying medical conditions. Additionally, the plan may cover other podiatry related services, please consult the member's plan benefits for details.

The Plan will utilize correct coding guidance from CMS in addition to other industry standard resources.

Reimbursement

The Plan will reimburse contracted Podiatrists for covered services. The Plan will use appropriate industry guidance for specific CPT/HCPCS and ICD-10 billing combinations. Failure to appropriately bill with the most specific and appropriate coding may result in the denial of a claim.

Referral/notification/prior authorization requirements

A PCP referral is required for Podiatry services. Some Podiatry procedures require prior authorization.

Effective June 1, 2020, routine foot care rendered by a Podiatrist will require prior authorization for NaviCare members.

Fallon Health Weinberg and NaviCare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

The Plan requires Podiatry service claims to be submitted with the most specific ICD-10 diagnosis for the procedure code utilized.

The list of codes is provided for reference only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Coverage of any of the bellows codes is subject to the member's benefits. Inclusion of a code does not imply reimbursement or guarantee claim payment.

Code	Description
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nail(s) by any method(s); 1 to 5
11721	Debridement of nail(s) by any method(s); 6 or more

11730	Avulsion of nail plate, partial or complete, simple; single
11732	Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)
11760	Repair of nail bed
11765	Wedge excision of skin of nail fold (eg, for ingrown toenail)
G0127	Trimming of dystrophic nails, any number
G0247	Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (lops) to include, the local care of superficial wounds (i.e. superficial to muscle and fascia) and at least the following if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

Place of service

This policy applies to services rendered in outpatient settings.

Policy history

Origination date: 12/01/2019

Connection date & details: October 2019 –Introduced as a new policy.

April 2020 – Updated Referral/notification/prior authorization requirements.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.