KAISER PERMANENTE® Mid-Atlantic States	**Routine Foot Care** **Medical Coverage Policy**

UTILIZATION * ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please consult the Medicare Coverage Database.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. Procedure: **Foot Care**

II. Specialty: Podiatry

III. **Clinical Indications for Referral**

A. Routine foot care is considered medically necessary based on the nature of services and covered when **any** of the following criteria is met:

1. The presence of systemic conditions associated with severe circulatory insufficiency, metabolic or neurologic conditions and/or areas of desensitization in the lower extremities, including but not limited to **either** of the following condition:
   a. peripheral vascular disease; or
   b. diabetes mellitus; or diabetic sensory neuropathy
   c. peripheral neuropathies involving the feet (such as numbness, loss of protective sensation)

2. In the absence of a systemic condition, for treatment of mycotic (fungal) nails, when **both** of the following conditions are met:
   a. If ambulatory, the degree of pain is severe causing difficulty with ambulation and/or abnormality of gait; and
   b. If non-ambulatory, there is pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate

3. When routine foot care is necessary and considered an integral part of a covered service such as:
   a. When trimming of nails is necessary for the treatment of an injury like fracture of the leg or foot such as to fit a cast; or
   b. To diagnose and treat infectious disease, ulcers, or wounds on the foot.

4. The presence of warts on the foot requiring thermal or chemical cautery and curettage treatments.

B. Treatment of Subluxations of the Ankle/Foot
   1. Medical or surgical treatment of subluxation of the ankle joint (talocrural joint); or
   2. Medical or surgical services to diagnose or treat medical conditions that have resulted from or are associated with partial displacement of foot structures (such as osteoarthritis that has resulted in a partial displacement of joints in the foot, and the primary treatment is for the osteoarthritis)

C. Therapeutic and Supportive Devices for the Feet
   Refer to *Medical Coverage Policy: Orthotics: Foot and Lower Extremity* for medical necessity criteria on supportive devices of the foot such as orthopedic shoes, therapeutic shoes, foot orthotics or shoe inserts.

IV. Exclusions

Foot care is considered not medically necessary and excluded from coverage for any of the following:

A. Routine foot care when the criteria cited in section III are not met.
The following are considered components of routine foot care and do not require the services of a qualified foot care provider or specialist. The list is not exhaustive.
   1. Trimming, cutting, clipping or debridement of nails; or
   2. Paring, cutting, or removing corns and calluses; or
   3. Cutting, paring, shaving or removal of keratoma, tyloma, and heloma; or
   4. Non-definitive simple, palliative treatment such as paring or shaving of plantar warts without the use of thermal or chemical cautery and curettage; or
   5. Hygienic or maintenance care of the foot (such as foot massage, application of foot creams, cleaning, soaking of the feet).

B. Surgical or non-surgical treatment of foot subluxation as an isolated entity for the sole purpose of correcting a subluxated structure in the foot; or

C. Treatment of flat foot; or
tions administered on the foot, in the absence of clinical requirements cited in section III; or

D. Procedures on the foot for convenience, aesthetic, or cosmetic purpose such as to improve the foot's appearance.

References:

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(Foot Orthoses) for pediatric flexible pes planus: A systematic review: Update. *PloS one*, *13*(2), e0193060. https://doi.org/10.1371/journal.pone.0193060

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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
01/26/2023	01/26/2023
01/24/2024	01/24/2024

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.