Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals

Overview
This fact sheet is designed to provide education on Medicare coverage of podiatry services. It includes an overview of routine foot care related to underlying systemic conditions, billing guidelines, and a list of resources.

Medicare Covered Foot Care Services
According to the "Medicare Benefit Policy Manual," Chapter 15, Section 290, Medicare covered foot care services
only include medically necessary and reasonable foot care.

Exclusions from Coverage
Certain foot care related services are not generally covered by Medicare. In general, the following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or
complexity of the procedure, are not covered by Medicare:

1. Treatment of Flat Foot
The term flat foot is defined as a condition in which one or more arches of the foot have flattened out. Services or
devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.

2. Routine Foot Care

Routine foot care is excluded from coverage, except as discussed below under "Conditions that Might Justify Coverage." The following services are normally considered routine and not covered by Medicare:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

3. Supportive Devices for Feet

Generally, Medicare will not cover orthopedic shoes and other supportive devices for the feet, unless it is an integral part of a leg brace and its expense is included as part of the cost of the brace. Also, a narrow exception permits coverage of therapeutic shoes and inserts for certain patients with diabetes.

TO OUR MEDICARE PATIENTS:

MEDICARE REQUIRES WRITTEN NOTIFICATION OF THE FOLLOWING:

If you are being treated for **routine care**, which includes cutting and grinding of **mycotic**, painful toenails and / or you have a systemic condition (such as diabetes or peripheral vascular disease) which requires professional foot care, Medicare will only pay for this service if it has been 61 days or more since you've last been treated. The doctor will inform you if you qualify for coverage based on Medicare's strict criteria

For example, if you come in on January 1st for routine care, you cannot be treated again until March 5th or later. If you develop another problem other than routine care as described above, this does not apply and you can be seen.

If you are seen less than 60 days apart, **MEDICARE WILL DENY THE SERVICE AND YOU WILL BE FULLY RESPONSIBLE FOR PAYMENT**.

Please remember this Medicare ruling when you make your follow-up appointments. It is especially important if you choose to call on the phone rather than making your appointment while you are in our office. We cannot be responsible if you make your follow-up appointments too early. For this reason, we strongly urge you to make your next appointment before leaving. This way we can minimize any scheduling mistakes.

Also, as of January 1, 1996, Medicare may deny certain routine foot care procedures. If any services are denied, **the patient is responsible for our total fee and will be billed accordingly**.

If you have any questions regarding scheduling, please feel free to speak with the receptionist.

I have read the above and understand the Medicare ruling regarding routine foot care:

_____ _____

PATIENT SIGNATURE **DATE**