

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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NC Medicaid
Medically Necessary
Routine Foot Care

Medicaid
Clinical Coverage Policy No: 1C-2
Amended Date: July 15, 2025

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:
1C-1, *Podiatry Services*

1.0 Description of the Procedure, Product, or Service

Medically necessary routine foot care is the cutting or removal of corns and calluses; trimming, cutting, clipping, or debriding of nails; and other hygienic care due to a physical or clinical finding that is consistent with a metabolic, neurological, and/or peripheral vascular disease diagnosis and indicative of severe peripheral involvement.

Note: In the absence of medical necessity, these services are considered routine and are not covered by the N.C. Medicaid program.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*.
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. Medicaid
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medically necessary routine foot care services will be covered **only** when:

- a. they are an integral part of otherwise covered services (refer to clinical coverage policy 1C-1, *Podiatry Services*, at <https://medicaid.ncdhhs.gov/>); or
- b. documentation illustrates the presence of metabolic, neurological, and/or peripheral vascular disease and indicative of severe peripheral involvement or provides evidence of specific active complications resulting from prior insults due to the aforementioned systemic conditions; or
- c. there is evidence of mycotic nail infection that in the absence of a systemic condition results in intolerable pain or secondary infection.

Medically necessary routine foot care, when provided by podiatrists, is covered for specific diagnoses only. Refer to Clinical Coverage Policy #1C-1, *Podiatry Services* (at <https://medicaid.ncdhhs.gov/>) **Attachment A** Section B for an approved list of diagnosis codes.

The recipient must be under the active care of a physician for the systemic condition.

Note: Curettement or shavings of lesion procedures are reviewed to determine if the service is routine foot care.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

In the absence of medical necessity, these services are considered routine and are not covered by Medicaid.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for medically necessary routine foot care.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

None Apply.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1988

Revision Information:

Date	Section Revised	Change
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
2/1/07	Attachment A	Corrected a diagnosis code (from 759.5 to 729.5) in Section B, #2.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
8/1/07	Attachment A, Letter B	Corrected a diagnosis code (from 719.77 to 719.7).
12/1/10	Section 1.0	Added standard DMA policy language
12/1/10	Section 3.0	Added standard DMA policy language
12/1/10	Subsection 3.1	Added standard DMA policy language and deleted "the procedures, are medically necessary"
12/1/10	Subsection 3.2	Changed heading from Medical Necessity to Specific Criteria. Added the wording to (b) and indicative of severe peripheral involvement. Added Medically necessary routine foot care, when provided by podiatrists, is covered for specific diagnoses only. Refer to Attachment A Section B Diagnosis Codes for an approved list of diagnosis codes.
12/1/10	Section 4.0	Added standard DMA policy language
12/1/10	Subsection 4.2	Changed Routine Foot Care to Specific Criteria
12/1/10	Section 5.0	Added standard DMA policy language
12/1/10	Section 6.0	Added "a. This policy applies to podiatrists, physicians and nurse practitioners. Added standard DMA policy language"
12/1/10	Section 7.0	Added EPSDT Language Added standard DMA policy language
12/1/10	Attachment A	Section A Claim Type, Section B Diagnosis Codes Added Professional (CMS-1500/837 P transaction) and Institutional (UB_04/837I transaction). Added Refer to Clinical Coverage Policy # 1C-1 Podiatry Services Attachment A Section B for approved list of diagnosis codes. Section E: Billing Units

Date	Section Revised	Change
		Section F: Place of Service Section G: Co-payments Updated Medicaid billing guide web address Section H: Reimbursement
7/1/10	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
3/12/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1C-2 under session Law 2011-145 § 10.41. (b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
5/1/12	Subsection 3.2	Removed the statement "such as plantar warts"
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/12/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/12/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
08/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.
07/15/2025	Section 5.1	4/1/22 Prior authorization for Medicaid for Pregnant Women (MPW) benefit service group (BSG) was removed. Updated the following to align: Removed prior approval requirement for medically necessary routine foot care for Medicaid for Pregnant Women coverage, to document medical necessity for services related to pregnancy or due to complications of pregnancy. Added Medicaid shall not require prior approval for medically necessary routine foot care.

Date	Section Revised	Change
07/15/2025	Section 5.2.1	Removed general prior approval requirements and added that none apply.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Debridement of nail(s) for a patient with infected mycotic nails and a systemic condition or marked ambulatory limitations due to pain or infection are covered with following primary and secondary ICD-10-CM diagnosis codes.

Primary ICD-10-CM Code(s)
B35.1

Secondary ICD-10-CM Code(s)			
L02.611	L03.041	M79.673	R26.1
L02.612	L03.042	M79.674	R26.2
L02.619	L03.049	M79.675	R26.81
L03.031	M79.671	M79.676	R26.89
L03.032	M79.672	R26.0	R26.9
L03.039			

Refer to clinical coverage policy 1C-1, *Podiatry Services* at <https://medicaid.ncdhhs.gov/>, **Attachment A** Section B for approved list of diagnosis codes when this service is provided by a podiatrist.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)	
11055	11719
11056	11720
11057	11721

HCPCS Code(s)
G0127

Note: When billing G0127 for trimming of dystrophic nails include on the claim an ICD-10 CM diagnosis code describing the recipient's systemic condition. The billing unit = 1 regardless of the number of nails that are trimmed.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines. Class findings refer to certain categories of physical and/or clinical findings consistent with the diagnosis given and indicative of severe peripheral involvement. The relevant modifiers are as follows.

Modifier
Q7
Q8
Q9

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>