Priority Health	BILLING POLICY No. 113
FOOT CARE & ONYCHOMYCOSIS TESTING	
Date of origin: June 2021	**Review dates: 7/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Routine foot care includes treatment of calluses, corns, keratotic and hyperkeratosis lesions, keratoderma, bunions (except capsular or bone surgery thereof) and nails (except surgery for ingrown nails. Information regarding coverage and medical necessity of these services can be found in Priority Health's Foot Care (#91121) medical policy.

Onychomycosis (mycotic nails) is fungal infection of the nail plate, nail bed or both. Infection may be distal subungual, with nail thickening and yellowing and accumulation of keratin and debris underneath the nail; proximal subungual or white superficial, with spreading of chalky white scale beneath the nail surface (bottom). It can be caused by ringworm or with other types of fungi such as yeasts.

MEDICAL POLICY

- Foot Care (#91121)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Priority Health podiatry services guidelines consider debridement of hyperkeratotic lesions (11055 – 11057) not separately reimbursable when performed with nail debridement (11720 – 11721) on the same digit based on National Correct Coding Initiative (NCCI) guidelines, Chapter 3. There are certain documentation requirements that providers should follow for proper reimbursement of the services rendered.

Documentation within the operative note should resemble the lay description of the CPT or HCPCS code selected. Documentation for repeated procedures on different anatomical sites (fingers, toes, limbs), spinal levels or paired organs should clearly detail each distinct procedure and support its medical necessity.

Documentation must include:

- The digit/location needing debridement

- The size of the lesion/debridement area
- The size (including thickness) and color of each affected nail
- Medical necessity for the debridement
- Debridement approach/surgical technique

Insufficient documentation examples:

- Documentation of location(s) ONLY within physical exam or objective area of the note. See Practitioner office documentation in this Manual for more.
- Documentation states only, "debridement of all affected nails," or "all hyperkeratotic lesions were debrided." Documentation must detail which nails or calluses were debrided or the extent to which they were debrided.

Coding specifics

Hyperkeratotic lesion debridement procedure codes

- **11055**: Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- **11056**: Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); 2 to 4 lesions
- **11057**: Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than 4 lesions

Nail debridement procedure codes

- **11720**: Debridement of nail(s) by any method(s); 1 to 5
- **11721**: Debridement of nail(s) by any method(s); 6 or more

Payable: When performed without nail debridement on the same digit and submitted with required documentation

Not payable: When performed with nail debridement (11720-11721) on the same digit. A modifier appended to indicate distinct services will not override this edit.

Nail trimming procedure codes

- G0127: Trimming of dystrophic nails, any number
- 11719: Trimming of nondystrophic nails, any number

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

A significant and separately identifiable service on the same day as routine care can be submitted with the modifier 25.

Incorrect application of modifiers will result in denials. Get more information on modifier us in our Provider Manual.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Article - Billing and Coding: Routine Foot Care (A52996) (CMS)
- LCD - Routine Foot Care (L35138) (CMS)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
July 11, 2025	Added clarifying information – including a definition, modifiers and references – to what was previously available in the Provider Manual.