

Modifiers Q7, Q8, and Q9 (Routine Foot Care)

CPT Modifier

Q7 One Class A finding

Q8 Two Class B findings

Q9 One Class B and two Class C findings

General Information

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare nail debridement payments, which is the single largest paid podiatric service. The OIG found that about one in every four claims did not include documentation of medical need for nail debridement in beneficiaries' medical records and that more than half of these inappropriate payments included other related inappropriate payments. This article explains the requirements for payment of Medicare claims for foot and nail services including information about routine foot care exclusion, exceptions to routine foot care exclusion, Class Findings, billing instructions, required claim information, and documentation on file.

Routine Foot Care Exclusion

Except as noted in "Exceptions to Routine Foot Care Exclusion" section, routine foot care is excluded from coverage. Services that are normally considered routine and not covered by Medicare include:

1. The cutting or removal of corns and calluses;
2. The trimming, cutting, clipping, or debriding of nails; and
3. Other hygienic and preventive maintenance care such as cleaning and soaking the foot, 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.

Exceptions to Routine Foot Care Exclusion

1. Services performed as a necessary and integral part of otherwise covered services such as diagnosis and treatment of ulcers, wounds, infections, and fractures.
2. The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional. Certain procedures that are otherwise considered routine may be covered when systemic condition(s), demonstrated through physical and/or clinical findings, result in severe circulatory embarrassment or areas of diminished sensation in the legs or feet and may pose a hazard if performed by a non-professional person on patients with such systemic conditions. In the case of patients with systemic conditions such as diabetes mellitus, chronic thrombophlebitis, and peripheral neuropathies involving the feet associated with malnutrition and vitamin deficiency, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, and uremia, they must also be under the active care of a doctor of medicine or doctor of osteopathy and who documents the condition in the patient's medical record.
3. Services performed for diabetic patients with a documented diagnosis of peripheral neuropathy and loss of protective sensation (LOPS) and no other physical and/or clinical findings sufficient to allow a presumption of coverage as noted in the Medicare Carriers Manual. This class of patients can receive an evaluation and treatment of the feet no more often than every six months as long as they have not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidelines. Five sites should be tested on the plantar surface of each foot, according to NIDDK guidelines.
4. Treatment of warts, including plantar warts, may be covered. Coverage is to the same extent as services provided for in treatment of warts located elsewhere on the body.
5. Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a non-ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Note: Active care is defined as treatment and/or evaluation of the complicating disease process during the six-month period prior to rendition of the routine care or had come under such care shortly after the services were furnished, usually as a result of a referral.

Class Findings

A presumption of coverage may be made by Medicare where the claim or other evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, the following findings are pertinent:

Class A Findings (1 needed)

Non-traumatic amputation of foot or integral skeleton portion thereof.

Use modifier Q7.

Class B Findings (2 needed)

1. Absent posterior tibial pulse
2. Absent dorsalis pedis pulse
3. Advanced trophic changes; three of the following are required:
 - hair growth (decrease or absence)
 - nail changes (thickening)
 - pigmentary changes (discoloration)
 - skin texture (thin, shiny)
 - skin color (rubor or redness)

Use modifier Q8.

Class C Findings (1 Class B, 2 Class C needed)

1. Claudication
2. Temperature changes
3. Edema
4. Paresthesia
5. Burning

Use modifier Q9.

Billing Instructions

The following are the main HCPCS/CPT codes for billing of foot and nail care services (additional codes can be found in the HCPCS/CPT code book):

- 11719** – Trimming of non-dystrophic nails, any number
- 11720** – Debridement of nail(s) by any method(s); one to five
- 11721** – Debridement of nail(s) by any method(s); six 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)

Routine foot care is covered for the following diagnoses only:

030.0 - 030.3	277.3	286.1	356.1	357.5	443.9
030.8	279.00 - 279.06	286.2	356.2	357.6*	444.22
030.9	279.09	286.3	356.3	357.7*	451.0*
042	279.10 - 279.13	286.4	356.4	357.81*	451.11*
079.53	279.19	286.5	357.0	357.82*	451.19*
094.0 - 094.1	279.2 - 279.4	286.6	357.1	357.89*	451.2*
250.60 - 250.63*	279.8	286.7	357.2*	440.20 - 440.24	
250.70 - 250.73*	279.9	286.9	357.3*	443.0	
272.7	286.0	356.0	357.4*	443.1	

1. Check with your local carrier for their list of codes as coverage criteria may vary from State to State.
2. Claims for routine foot care, which include one of the diagnoses designated by an asterisk, must indicate in block 19 of the CMS-1500 claim form, the date the patient was last seen by the medical doctor who is currently treating the systemic condition and that physician's NPI.
3. The diagnoses in the aforementioned list do not by themselves constitute medical necessity for routine foot care services. In addition to a covered diagnosis, the class finding (signs and symptoms) of the underlying systemic disease must be documented in the patient's medical records. These signs and symptoms fall into three class findings and the classes are represented by the three modifiers on page 1-47.
4. For complete Medicare guidelines for your local carrier, go to the CMS website and search the Medicare Coverage Database at <http://cms.hhs.gov/mcd>.

Example: The patient has severe diabetes resulting in the amputation of three of his toes on the left foot. The patient is being treated by your office for routine foot care during which time you trim the nails, soak the feet, and monitor their foot fungus. Your documentation is up to snuff. You bill:

19. Reserved For Local Use								
04-21-07 George Brown MD A12345								
21. Diagnosis Or Nature Of Illness Or Injury (Relate Items 1,2,3 Or 4 To Item 24E By Line)								
1. I 250.70		3. I _____						
2. I _____		4. I _____						
24. A		B	C	D		E	F	G
Date(s) of Service		Place of Service	EMG	Procedures, Services, or Supplies (Explain Unusual Circumstances)		Diagnosis Pointer	\$ Charges	Days or Units
MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER	
05	09	07				11719	Q7	
			11					
							1	
							5000	1

Required Claim Information

- Item 17. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. A referring physician is a physician who requests an item or service for the patient for which payment may be made under the Medicare program.
- Item 17b. Enter the CMS assigned NPI of the referring/ordering physician listed in item 17.
- Item 24J. Enter the name of the rendering or supervising physician.
- Item 19. Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims.
- Item 21. Enter the patient’s diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

- Item 24D. Enter the procedures, services, or supplies using the HCPCS/CPT code. When applicable, show HCPCS modifiers with the HCPCS code. Enter the Q7 – One Class A finding; Q8 – Two Class B findings; or Q9 – One Class B and two Class C findings as appropriate.

Enter the specific procedure code without a narrative description.

7. Item 24E. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; enter either a 1, or a 2, or a 3, or a 4.

If a situation arises where two or more diagnoses are required for a procedure code, *you must reference only one of the diagnoses in item 21.*