Prior Authorization Guideline

Podiatry, Routine Foot Care and Related Foot Services

Procare MSO and the IPAs it administers, including Premier Patient Care IPA

Field	Entry
Guideline	Podiatry, Routine Foot Care and Related Foot Services
Version	09/27/2026.
Applies to	All practitioners and facilities requesting podiatry and foot care services for a member whose utilization management is delegated to Procare MSO. Medicare Advantage, D-SNP and C-SNP, and Commercial.
Policy number	To be assigned by Compliance before posting.
Effective date	To be entered on approval by the Utilization Management Committee.
Review cycle	Annual, and on any change to a coverage determination cited below.
Questions	Utilization Management, outpatient. authorization@procaremso.com, (657) 206-8700, fax (855) 405-2288.
Finding	
THE POINT THAT DECIDES MOST OF THESE REQUESTS. Routine foot care is EXCLUDED FROM MEDICARE BY STATUTE. It is not a service that is covered and then measured for medical necessity. Where an exception applies the service is covered and is then assessed like any other; where no exception applies the service is non-covered and no clinical criteria are reached at all. The difference is not academic. It decides who may make the decision, what the notice says, and what an appeal is about.	

1. How Procare decides

Medical necessity criteria are applied in the order set by Procare policy UM-00101, Clinical Criteria: (A) a CMS National Coverage Determination; (B) the Local Coverage Determination or Article of the Medicare contractor for California, which is Noridian Healthcare Solutions, Jurisdiction E, and for durable medical equipment the Noridian DME MAC, together with any State requirement that exceeds the federal one; (C) the CMS Internet Only Manuals; (D) MCG Health 30th Edition, in the absence of a Medicare source and with the higher rungs documented as unavailable; (E) the member's health plan medical policy; (F) peer reviewed literature and professional standards. Exactly one rung governs each code and the walk stops there.

A policy issued by a Medicare contractor other than Noridian is not applied to a California member. THE SOCIAL SECURITY ACT IS NOT A STEP IN THAT ORDER. It is the statute the whole order implements: section 1862(a)(1)(A) for the reasonable and necessary standard, or the specific statutory exclusion where one applies.

2. Routine foot care is a statutory exclusion, and that changes everything downstream

Section 1862(a)(13)(C) of the Social Security Act excludes routine foot care from Medicare coverage. 42 CFR 411.15(l) and the Medicare Benefit Policy Manual, CMS Publication 100-02, Chapter 15, Section 290 set out the exclusion and the exceptions to it.

Because it is an exclusion and not a necessity question	What follows
The decision is a BENEFIT decision.	It is finalized by a nurse reviewer or a utilization management coordinator. It does not require the Medical Director, and it should not be routed to him as a necessity question.

The notice cites the EXCLUSION.	It names section 1862(a)(13)(C), 42 CFR 411.15(l) and Publication 100-02 Chapter 15 Section 290, states which exception was considered and what the record does not show for it, and carries NO medical necessity language at all.
The member DOES receive a written notice.	A non-covered benefit determination is an adverse organization determination. The member receives notice with appeal rights and is held harmless.
What the appeal is about is different.	Not whether the service was needed, but whether an exception to the exclusion is established. A notice that argues necessity invites an appeal on the wrong question and usually loses it.
This holds whoever signed it.	If a determination on an excluded service happens to be rendered by the Medical Director, and even if it uses the words medical indication not met, the ground is still the exclusion and the notice still cites the exclusion. The determination decides the outcome; the ground decides the basis, the rendering authority and the letter.

2a. The exception, and what the record must contain to reach it

Routine foot care becomes payable where the member has a qualifying systemic condition of a severity that makes it hazardous for a non-professional to perform the care, or on the other exceptions the manual sets out including mycotic nails with documented symptoms. To reach the exception the record must contain all of the following.

Required	Detail
The qualifying systemic condition	Named, with its diagnosis code.
Active care for that condition	THE NAME OF THE PHYSICIAN TREATING THE SYSTEMIC CONDITION AND THE DATE THE MEMBER WAS LAST SEEN BY THAT PHYSICIAN. This is the element most often missing, and it is the element the exception turns on.
The class findings	The documented class findings supporting the exception, recorded from the examination rather than asserted.
For nail debridement specifically	Mycosis, WITH documented pain or a marked limitation of ambulation. Thickened or discoloured nails alone do not establish it.
The correct modifier	Apply the Q modifier that corresponds to the class findings documented.

Without these the service is non-covered, and no clinical criteria are reached or cited.

3. The contractor check, because this is where routine foot care goes wrong

California is served by Noridian Healthcare Solutions, Jurisdiction E. NORIDIAN HAS NO LOCAL COVERAGE DETERMINATION ON ROUTINE FOOT CARE. Verified against the Medicare Coverage Database on 09/18/2026.

Five other Medicare contractors do publish one. They are easy to find, they say broadly similar things, and NONE of them applies to a member in California. Borrowing one is a wrong-contractor rejection.

Policy	Contractor	Applies to a Procare California member?
L34246 Routine Foot Care and Debridement of Nails	CGS Administrators	NO
L33636 Routine Foot Care and Debridement of Nails	Wellpoint Federal	NO
L37643 Routine Foot Care	Palmetto GBA	NO
L35138 Routine Foot Care	Novitas Solutions	NO
L33941 Routine Foot Care	First Coast Service Options	NO

So for a Procare member the governing authority on routine foot care is the STATUTE and the MANUAL, at rungs A and C, and not a local coverage determination at rung B. Rung B is empty and the document says so with the date it was searched.

4. Services, authority applied, and what the request must show

Service and codes	Authority applied	The request must document
ROUTINE FOOT CARE. Paring or cutting of benign hyperkeratotic lesions 11055, 11056, 11057. Nail trimming and debridement 11719, 11720, 11721, G0127.	STATUTORY EXCLUSION. Social Security Act section 1862(a)(13)(C); 42 CFR 411.15(l); CMS Publication 100-02, Chapter 15, Section 290. No Noridian local coverage determination.	Everything in section 2a. Excluded by statute unless an exception is established.
NAIL AND SOFT TISSUE PROCEDURES. Nail plate avulsion 11730, 11732. Excision of nail and matrix 11750. Nail biopsy 11755. Incision and drainage 10060, 10061. Lesion shaving and excision 11305, 11420.	Section 1862(a)(1)(A). No National Coverage Determination and no Noridian local coverage determination on these codes.	The diagnosis; the symptoms and their duration; the conservative measures already tried and their result; and, for a repeat procedure on the same site, what has changed. Note that where the documented service is maintenance debridement of a callus, an excision code does not describe it and the service remains routine foot care under section 2.
WOUND CARE. Subcutaneous tissue debridement 11042, 11043. Open wound selective debridement 97597. Low frequency non-contact ultrasound 97610.	Section 1862(a)(1)(A). MCG Health, GRG Wound and Skin Management, 30th Edition, where applicable.	Wound location, measurements and depth; the tissue actually removed and the instrument used; the treatment plan; and, on serial debridement, the measured response since the last one.
NON-INVASIVE VASCULAR STUDIES AND VASCULAR TREATMENTS. Arterial physiologic studies 93922, 93923, 93924; arterial and venous duplex 93925, 93926, 93930, 93931, 93970, 93971; carotid and abdominal duplex 93880 to 93893 and 93975 to 93979; venous ablation and sclerotherapy 36465 to 36479 and 37700 to 37780; arterial revascularization.	OUTSIDE THE PODIATRIC SCOPE OF PRACTICE. Social Security Act section 1861(r); 42 CFR 410.20(b); California Business and Professions Code section 2472(b); 42 CFR 410.32(a). National Coverage Determination 20.14, Plethysmography, recorded, not applied. See section 5.	Not reviewed for medical necessity from a podiatry office. The request is cancelled and the referral is redirected through the member's primary care provider to a cardiologist or vascular surgeon, who submits the request.
EXTREMITY ULTRASOUND AND GUIDANCE. 76881, 76882. Ultrasound guidance for needle placement 76942.	Section 1862(a)(1)(A).	The clinical question the study answers; a permanent recorded image; and a written interpretation. For 76942, why guidance was required for that injection and the image showing needle placement.
INJECTIONS. Tendon sheath, ligament or aponeurosis 20550. Small and intermediate joint arthrocentesis or injection 20600, 20605. Peripheral nerve block 64450. Drug J0702.	Section 1862(a)(1)(A).	The exact site; the agent and dose; the response to any prior injection at the same site; and the conservative measures tried.
STRAPPING, CASTING AND SUPPLIES. 29405, 29540, Q4038.	Section 1862(a)(1)(A). CMS Publication 100-02, Chapter 15.	The injury or condition treated, the material applied, and why the application was needed on that date rather than dispensed as a supply.
THERAPEUTIC SHOES AND INSERTS FOR PERSONS WITH DIABETES. A5500, A5501, A5512, A5513, A5514.	Social Security Act section 1861(s)(12). CMS Publication 100-02, Chapter 15, Section 140. DME MAC Local Coverage Determination L33369, Therapeutic Shoes for Persons with Diabetes, Noridian DME MAC.	The certifying statement from the physician MANAGING THE DIABETES, who is not the supplier; the diabetes diagnosis; at least one qualifying foot condition; the in-person examination; the prescription; and the annual limit of one pair of shoes and three pairs of inserts per calendar year. The insert rides with the shoe and is not authorized separately.
ORTHOSES. Ankle-foot orthoses L4397, L4361, L1902. Knee orthoses L1971.	DME MAC Local Coverage Determination L33686, Ankle-Foot /	The covered indication in the determination; THE CONSERVATIVE

	Knee-Ankle-Foot Orthosis, Noridian DME MAC. For knee orthoses, L33318, Knee Orthoses, Noridian DME MAC.	TREATMENT ALREADY TRIED AND ITS RESULT, with dates; the fitting and measurements; and the supplier.
EVALUATION AND MANAGEMENT. 99202 to 99215.	Section 1862(a)(1)(A). CMS Publication 100-04, Chapter 12, Section 30.6.	The level billed must match the documented medical decision making or total time. Where a procedure is performed at the same encounter, a separately identifiable service must be documented and modifier 25 applied. One visit level per encounter: two levels of the same basis can never both be payable.
PHYSICAL PERFORMANCE TESTING 97750. AUTONOMIC AND SUDOMOTOR TESTING 95923.	Section 1862(a)(1)(A).	The specific test performed, the time spent, the measured result, a written report, and how the result will change management.

5. Vascular studies and vascular treatments from a podiatry office are outside the scope of practice

A NON-INVASIVE VASCULAR STUDY OR A VASCULAR TREATMENT REQUESTED BY A PODIATRIST IS CANCELLED AS OUTSIDE THE PODIATRIC SCOPE OF PRACTICE, WHATEVER THE DIAGNOSIS. It is not reviewed for medical necessity, no clinical criteria are scored, and it is not a denial: the member is held harmless and no member denial notice issues. The requesting office receives a cancel letter stating the reason and the reference. The member's primary care provider is notified and asked to redirect the referral to a cardiologist or vascular surgeon, or is told of the cardiology or vascular surgery authorization the member already holds for the same studies. The cardiologist or vascular surgeon submits the request, which is then reviewed on its merits under the applicable coverage determination.

Reference	What it establishes
Social Security Act section 1861(r); 42 CFR 410.20(b)	A doctor of podiatric medicine is a physician for Medicare purposes only with respect to the functions he or she is legally authorized by the State to perform.
California Business and Professions Code section 2472(b)	Podiatric practice in California is limited to the foot and ankle. Evaluation and treatment of the arterial and venous system of the limb is vascular medicine.
42 CFR 410.32(a)	A diagnostic test is ordered by the physician who treats the beneficiary for the condition and who uses the result in managing it. A vascular study drives a revascularization or anticoagulation decision that a podiatrist does not make.
42 CFR 422.4(a)(1)(ii); 42 CFR 422.112(a)	A Medicare Advantage coordinated care plan routes specialty care through the primary care provider and coordinates it. The redirect through the primary care provider is that mechanism.
National Coverage Determination 20.14, Plethysmography, effective 11/15/1980	Recorded, not applied. Its podiatric sentence reaches only "the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which have a bearing on the patient's candidacy for foot surgery", and it is the coverage determination the cardiologist or vascular surgeon's request is reviewed under.

THE PODIATRIC SENTENCE OF NCD 20.14, QUOTED IN FULL. It has three limbs, not two. A podiatry request does not reach it: the request is cancelled for scope before any coverage determination is applied. The limbs are set out here so the redirected specialist request can be read against them.

Limb	Reaches
1. The diabetic patient	A member with diabetes.
2. Intermittent claudication	A member with documented claudication.

3. OTHER SIGNS OR SYMPTOMS INDICATIVE OF PERIPHERAL VASCULAR DISEASE	A non-diabetic member without claudication who has, for example, non-palpable pedal pulses. This limb is real and it is the one that was being missed.
Also required, and frequently missing	**Detail**
The bearing on candidacy for FOOT SURGERY	The qualifier governs all three limbs. A study ordered where no foot surgery is contemplated, or where surgery is expressly deferred, does not reach the podiatric sentence at all. A partial nail avulsion is not the kind of surgery the determination is addressed to. A podiatry request is cancelled for scope before this question arises; the limbs are read against the redirected specialist request.
THE DEVICE, BY NAME	Category I techniques are covered: segmental plethysmography (regional, differential, recording oscillometer, pulse volume recorder), electrical impedance, ultrasonic Doppler flow measurement, oculoplethysmography and strain gauge. CATEGORY II IS NATIONALLY NON-COVERED: inductance, capacitance, mechanical oscillometry and photoelectric. The record almost never names the device, and without it the study cannot be placed in Category I at all.
The office setting raises the bar, it does not lower it	For an office setting the determination says venous occlusive pneumoplethysmography is unsuitable for routine use in the physician office, and that for other techniques reimbursement for studies done by techniques other than venous occlusive pneumoplethysmography should be denied. Place of service 11 therefore makes the requirement stricter.
The descriptor	93922 requires ankle brachial indices PLUS bidirectional Doppler waveform recording and analysis at one to two levels. An ankle brachial index alone does not meet the descriptor, and that is a coding question rather than a necessity question.

NCD 220.5 covers peripheral Doppler flow studies as a MODALITY and non-covers B-scan for peripheral atherosclerosis. It is a list of accepted modalities with no patient level indication in it, so no record can be scored against it and it is never the source a necessity decision rests on.

6. Standing requirements for every podiatry request

Requirement	Detail
Scope of practice	Both the service requested and the diagnosis supporting it must sit within the scope of podiatric practice, the foot and ankle, California Business and Professions Code section 2472(b). A request outside that scope is cancelled and redirected through the primary care provider to the appropriate specialist; it is never denied on medical necessity. Non-invasive vascular studies and vascular treatments are outside that scope, section 5.
Ordered by the treating practitioner	The service is ordered by the practitioner who will use the result in managing the specific problem. 42 CFR 410.32(a).
Serial and repeat visits	Where a member is seen repeatedly for the same condition, each request must document what has changed since the last encounter and why the service is needed again. Routine interval follow-up with no change in findings is not a covered indication.
Conservative treatment first	Where a device, an orthosis or a procedure has a recognised conservative alternative, the record must show that alternative was tried, with dates and result, or say why it is contraindicated.
Place of service and who furnished the service	The place of service on the request and on the claim is where the service was actually furnished.
Correct coding	Where a code is a component of another requested code, criteria are applied to the principal code and the component is not separately authorized. National Correct Coding

	Initiative edits apply.

7. Determinations, notices and appeals

Point	Detail
Who may deny	ONLY the Medical Director renders a denial based on medical necessity, and a nurse reviewer may not. A STATUTORY EXCLUSION, a benefit limit or a correct coding outcome is finalized by a nurse or utilization management coordinator and is not a medical necessity decision. A CANCELLATION for a service outside the requesting specialty's scope of practice, or for a duplicate of a service already rendered by another specialist, is likewise finalized by a nurse or utilization management coordinator, with the cancel letter to the requesting office and notice to the primary care provider. Where any requested line on an authorization is not met on medical necessity, the authorization is reviewed by the Medical Director.
What an adverse determination states	For a necessity denial: the criterion applied by name with its source and effective date, the element of it that is not met, and what the submitted records do not show against that element. For an excluded service: the statutory or regulatory exclusion, the exception considered, and what the record does not establish for it. The two are never mixed.
Denial is for absence of clinical need, never absence of paperwork	A determination does not read that a service was denied because something was "not in the notes". It names what the service clinically requires and what this member's record does not establish.
Member notice	A denial in whole or in part produces a written member notice with appeal rights, including on a non-covered benefit. 42 CFR 422.566 and 422.568. A correct coding outcome goes to the provider notice only.
Timeframes	Standard pre-service determinations no later than 7 CALENDAR DAYS from receipt. Expedited within 72 HOURS where the standard timeframe could seriously jeopardize the member. Expedited Part B drug within 24 HOURS. Retrospective within 30 CALENDAR DAYS. CMS-0057-F effective 01/01/2026, with 42 CFR 422.568 and 422.572.
Held harmless	The member is not billed for a service denied under this guideline. 42 CFR 422.504(g)(1)(iii).

8. Submitting and contacts

Purpose	Contact
Prior authorization	Provider portal https://procaremso.quickcap.net/procare/general/index.php | authorization@procaremso.com | (657) 206-8700 | fax (855) 405-2288
Peer to peer	P2P@procaremso.com | (657) 206-8700
A copy of the criteria applied, free of charge	UM@procaremso.com | (657) 206-8700
Provider disputes and appeals	providerdisputes@procaremso.com | ProCare MSO, PO Box 25629, Santa Ana, CA 92799
General	support@procaremso.com | (657) 206-8700 | www.procaremso.com | ProCare MSO, 1503 S Coast Drive, Suite 212, Costa Mesa, CA 92626

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