Podiatric Q Modifiers

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This policy outlines reimbursement guidelines for routine footcare with the use of Q modifiers. While routine foot care is typically considered an excluded service, there are exceptions under which it may be covered by Molina Healthcare.

Payment for routine foot care may be provided in the following situations:

- When the patient has a systemic disease, such as metabolic, neurologic, or peripheral vascular disease.
- When the performance of routine foot care by a nonprofessional may put the patient at risk due to sudden severity.

Additionally, procedures for treating toenails are covered under specific circumstances:

- Onychogryphosis (long-standing thickening of the nail): Coverage is provided when it results in marked limitation of ambulation, pain, secondary infection, symptomatic indentation, or minor laceration.
- Onychauxis (thickening of the nail/nail bed): Coverage is provided when it results in marked limitation of ambulation, pain, secondary infection, and associated symptoms.

Reimbursement Guidelines

To qualify for reimbursement for routine foot care services, the patient record must document physical and clinical findings indicative of severe peripheral involvement.

Routine foot care includes the following services, regardless of the provider:

- Cutting or removal of corns and calluses.
- Clipping, trimming, or debridement of nails, including mycotic nails.
- Shaving, paring, cutting, or removal of keratoma, tyloma, and heloma.
- Non-definitive simple, palliative treatments such as shaving or paring of plantar warts.
- Other hygienic and preventive maintenance care.

Coverage for the treatment of foot warts, diabetic ulcers, wounds, and infections may also be available.

Treatment of mycotic nails may be covered under exceptions to routine foot care exclusion. For coverage, specific criteria must be met, including clinical evidence and the presence of qualifying systemic illnesses causing peripheral neuropathy.

Class Findings:

- Class A: Non-traumatic amputation of the foot or integral skeletal portion.
- Class B: Absent posterior tibial pulse, advanced trophic changes, and absent dorsalis pedis pulse.
- Class C: Claudication, temperature changes, edema, paresthesia, and burning.

Global surgery rules apply to routine foot care procedure codes, and modifier 25 may be used when billing for E&M services on the same day as routine foot care.

When billing for specific procedure codes, modifiers Q7, Q8, and Q9 must be reported based on the presence of class findings, unless the patient has evidence of neuropathy without vascular impairment. Incorrect billing may result in payment delays or denials, and Molina Healthcare may conduct recovery for incorrectly paid claims.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services

State Exceptions

State	Exception
AZ	Arizona Medicaid will cover podiatry services for members over 21 years of age.

Documentation History

Type	Date	Action
Initial Creation Date	09/08/2023	New Policy
Revised Date	12/17/2024	Updated Template and verified reference Links
Revised Date	08/05/2025	Updated Template

References

References This policy was developed using:

• CMS
• State Medicaid Regulatory Guidance
• State Contracts

Reference	Link
CMS	Article - Billing and Coding: Routine Foot Care (A57188)
CMS	LCD - Routine Foot Care (L33941)

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding*

practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.