Podiatry Documentation Checklist

Routine foot care exclusions, Q-modifier documentation, and DME billing — what Medicare actually requires to pay the claim.

Routine foot care: the exclusion and the exception

RULE	WHAT IT MEANS
Default: excluded	Medicare excludes routine foot care (nail trimming, callus removal) as a matter of policy, unless a qualifying exception applies.
Exception: at-risk condition	Coverage applies when a systemic condition — most commonly diabetes with peripheral neuropathy or vascular disease — makes routine care medically necessary.
Documentation standard	The at-risk condition must be documented at the visit, not assumed from a prior diagnosis on file.

Q-modifiers

MODIFIER	MEANING
Q7	One Class A finding.
Q8	Two Class B findings.
Q9	One Class B and two Class C findings.

Documentation note: Using the correct Q-modifier without the supporting class findings documented is functionally the same as using the wrong modifier — the claim is judged on the documentation attached, not the code alone.

Top billing mistakes we see

MISTAKE	FIX
At-risk condition assumed, not documented	Re-document the qualifying condition at every visit where routine foot care is billed.
DME billed like an office visit	Diabetic shoes and orthotics run on separate DME documentation requirements — handle as its own workflow.
Nail debridement frequency ignored	Frequency limits vary by payer — verify before billing repeat debridement services.

Sources: Centers for Medicare & Medicaid Services, Medicare Coverage Database (cms.gov). American Podiatric Medical Association (apma.org). This guide is for general informational purposes and does not replace payer-specific verification.