

Podiatry Coding & Compliance Quick Reference

A one-page teaser covering routine foot care coverage rules and lower-extremity procedures — practical starting points for coders, billers, and providers. This is general education, not a substitute for payer-specific policy or a full audit.

Documentation Musts

- Systemic condition (e.g., diabetes, peripheral vascular disease) justifying "routine" foot care documented at every visit, not just on the initial encounter.
- Class Findings / risk category clearly stated and consistent with the frequency of visits billed.
- Nail and callus/corn debridement documented per digit/lesion, not as a blanket statement.
- Physician referral or co-management notes on file when required by the payer for routine care coverage.

Common Denial Triggers

- Routine foot care billed without an active, qualifying systemic diagnosis on the claim.
- Visit frequency exceeding payer-defined intervals without supporting clinical justification.
- Debridement codes billed by lesion count that doesn't match the documented count.

Modifier Watch-Outs

Toe/digit modifiers and the Q7/Q8/Q9 class-findings modifiers are podiatry-specific and are frequently omitted or mismatched to the documented risk class — this is one of the most common audit findings in the specialty.

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