# Routine Foot Care and Debridement of Nails

6/30/2021

# Today's Presenters

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# Objective

- To help providers better understand how important it is to apply the LCD for Routine Foot Care and Debridement of Nails (L33636)

# Agenda

- LCD for Routine Foot Care and Debridement of Nails – L33636
- Related Local Coverage Article – A57759
- Billing Tips
- NCCI
- Medical Review
- Resources

# Services Considered to be Components of Routine Foot Care

- Routine foot care generally not covered
  - Cutting or removal of corns and calluses
  - Clipping, trimming, or debridement of nails, including debridement of mycotic nails
  - Shaving, paring, cutting or removal of keratoma, tyloma, and heloma
  - Nondefinitive simple, palliative treatments

# Services Considered to be Components of Routine Foot Care

- Other hygienic and preventive maintenance care in the realm of self care
  - Cleaning and soaking the feet
  - Use of skin creams to maintain skin tone of both ambulatory and bedridden patients
  - Any services performed in the absence of localized illness, injury, or symptoms involving the foot

# Billing CPT/HCPCS Codes

| Code | Description |
|---|---|
| 11055 | Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); single lesion |
| 11056 | Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); 2 to 4 lesions |
| 11057 | Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); More than 4 lesions |
| 11719 | Trimming of nondystrophic nails, any number |
| 11720 | Debridement of nails(s) by any method(s); 1 to 5 |
| 11721 | Debridement of nails(s) by any method(s); 6 or more |
| G0127 | Trimming of dystrophic nails, any number |

# Billing CPT/HCPCS Codes, Unit 1

- CPT Coding
  - Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127 should be billed with a UNIT of “1” regardless of the number of lesions or nails treated

# Medicare Does Not Routinely Cover Fungus Cultures and KOH Preparations in Office

- Identification of cultures of fungi in the toenail clippings is medically necessary only
  - When it is required to differentiate fungal disease from psoriatic nail
  - When a definitive treatment for prolonged period of time is being planned involving the use of a prescription medication

# Indications of Coverage

- Specific indications or exceptions under which routine foot care are program benefits
  - Systemic disease
    - Metabolic
    - Neurologic
    - Peripheral vascular disease
- Must be of sufficient severity that performance of such services by a nonprofessional person would put patient at risk

# Indications of Coverage

- Coverage available for patients with peripheral neuropathy involving the feet, but without the vascular impairment as outlined in class B finding
  - Refer to group three or four paragraph and group three or four codes for those diagnoses where the patient has evidence of neuropathy, but no **vascular impairment**, for which class findings modifiers are not required

# Indications of Coverage

- Services considered routine may be covered if they are performed as an integral part of otherwise covered services
  - Diagnosis and treatment of ulcers
  - Wounds
  - Infections
- Treatment of mycotic nails may be covered under the exceptions to the routine foot care exclusion (requires two DX)

# Indications of Coverage

- Treatment of warts on the foot is covered to same extent as services provided for treatment of warts located elsewhere on body
- Removal of warts for cosmetic purposes or with at-home remedies is not covered through Medicare
  - If the beneficiary wishes one or more benign asymptomatic lesions removed for cosmetic purposes, the beneficiary becomes liable for the service(s) rendered

# Coverage of Mycotic Nails, Onychogryphosis, Onychauxis

- Coverage for treatment of mycotic nails, onychogryphosis and onychauxis may be covered under the following
  - Presence of qualifying systemic illnesses with class findings
  - Presence of a peripheral neuropathy without class findings
  - In the absence of systemic or neuropathic disease as defined on next slides

# Coverage of Mycotic Nails with Absence of Systemic Condition

- In the absence of a systemic/neuropathy condition, specific criteria must be met in the case of ambulatory/nonambulatory patients
- Ambulatory patients
  a) Clinical mycosis of nail
  b) Marked limitation of ambulation, pain and/or secondary infection resulting from thickening/dystrophy of nail plate
- Nonambulatory patients
  a) Clinical mycosis of nail
  b) Pain and/or secondary infection resulting from thickening/dystrophy of nail plate

# Coverage of Onychogryphosis and Onychauxis

- Procedures for treating toenails are covered for onychogryphosis and onychauxis
  - Presence of qualifying systemic illnesses with class findings
  - Presence of a peripheral neuropathy without class findings
  - In absence of systemic/neuropathic disease
    - For **onychogryphosis** there is marked limitation of ambulation, pain and/or secondary infection where the nail plate is causing symptomatic indentation of or minor laceration of the affected distal toe
    - For **onychauxis** there is marked limitation of ambulation, pain and/or secondary infection that is causing symptoms

# Modifiers CMS 1500 Item 24D

- One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, and 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, EXCEPT where the patient has evidence of neuropathy, but no vascular impairment
  - Modifier Q7: One class A finding
  - Modifier Q8: Two class B findings
  - Modifier Q9: One class B finding and two class C findings

# Class A Findings / Modifier Q7

- The presumption of coverage may apply when the physician rendering routine foot care has identified one class A finding
  - Nontraumatic amputation of foot or integral skeletal portion thereof

# Class B Findings / Modifier Q8

- Absent posterior tibial pulse
- Absent dorsalis pedis pulse
- Advanced trophic changes as evidenced by any three of the following **(three required)**
  - hair growth (decrease or absence)
  - nail changes (thickening)
  - pigmentary changes (discoloration)
  - skin texture (thin, shiny)
  - skin color (rubor or redness)

# Class C Findings / Modifier Q9

- The presumption of coverage may apply when the physician rendering the routine foot care has identified **one class B and two class C**
  - Claudication
  - Temperature changes (e.g., cold feet)
  - Edema
  - Paresthesia's (abnormal spontaneous sensations in the feet)
  - Burning

# Billing Tips

# Specific Items to Look for

- ICD-10 codes that support medical necessity
  - There may be multiple groups of ICD-10 codes
  - It is important to read the narrative at the beginning of each ICD-10 group to understand which CPT codes apply to the list of ICD-10 codes

# ICD-10 Codes that Support Medical Necessity

- Group 1 Paragraph
  - Codes: 11055, 11056, 11057, 11719,11720,11721 and G0127
- Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation

  * For these diagnoses, the patient must be under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified nonphysician practitioner for the treatment and/or evaluation of the complicating disease process during the six month period prior to the rendition of the routine-type service

# Treatment of Mycotic Nails, Onychogryphosis or Onychauxis

- Codes: 11719, 11720, 11721 and G0127
- In the absence of a systemic condition or where the patient has evidence of neuropathy, but no vascular impairment, for which **class findings modifiers are not required** these ICD-10 CM codes must be reported as primary
  - B35.1 Tinea unguium
  - L60.2 Onychogryphosis
  - L60.3 Nail dystrophy
- The diagnosis representing the patient's symptom must be reported as the secondary ICD-10-CM code
  - Refer to Group 3 for the secondary ICD-10-CM codes required for coverage

# Group 4 Paragraph

- 11055, 11056, 11057, 11719, 11720, 11721 and G0127
- The ICD-10-CM codes in the Group 4 paragraph represent those diagnoses where the patient has
  - Evidence of neuropathy
  - No vascular impairment
  - Class findings modifiers are not required
    - Refer to LCD in Group 4 codes

# Claim Submission Requirements

- Date last seen by attending physician
  - The approximate date when the beneficiary was last seen by the MD/DO or NPP who diagnosed the complicating condition must be reported in an eight-digit format in Item 19 of the CMS-1500 claim form or the electronic equivalent
- NPI of the attending physician
  - The NPI of the attending physician must be reported in Item 19 of the CMS-1500 claim form or the electronic equivalent

# Documentation Requirements

- Refer to the LCD for documentation requirements specific to the service being rendered and billed
- Document physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement
- Physical findings and services must be precise and specific (e.g., left great toe, or right foot, 4$^{th}$ digit)
- Documentation of coexisting systemic illness should be maintained

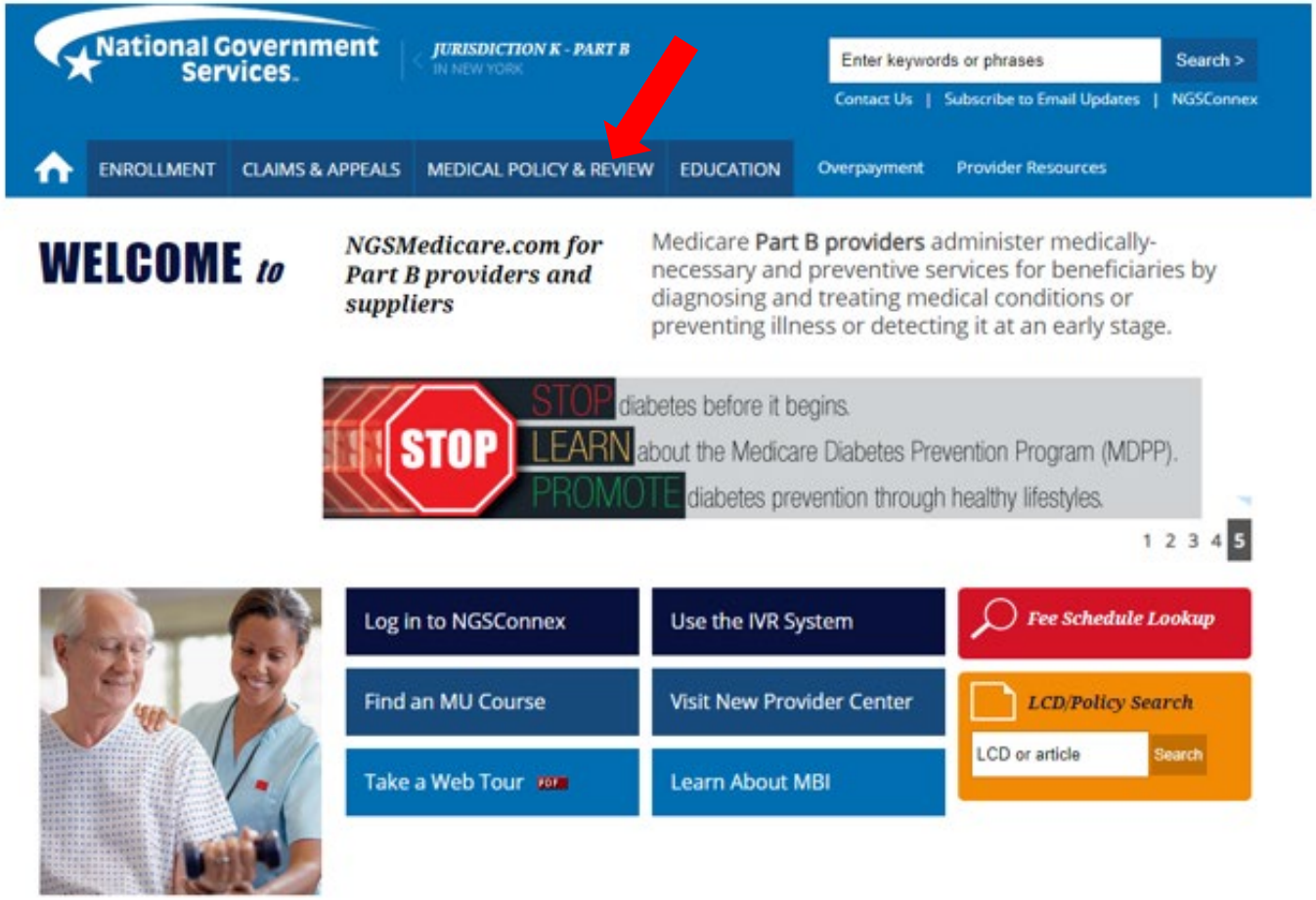
# Utilization Guidelines

- Routine foot care services are considered medically necessary once in 60 days
- More frequent services will be considered not medically necessary
  - 60-day calculations are available
    - Podiatry Calculator
- Services for debridement of more than five nails in a single day may be subject to special review

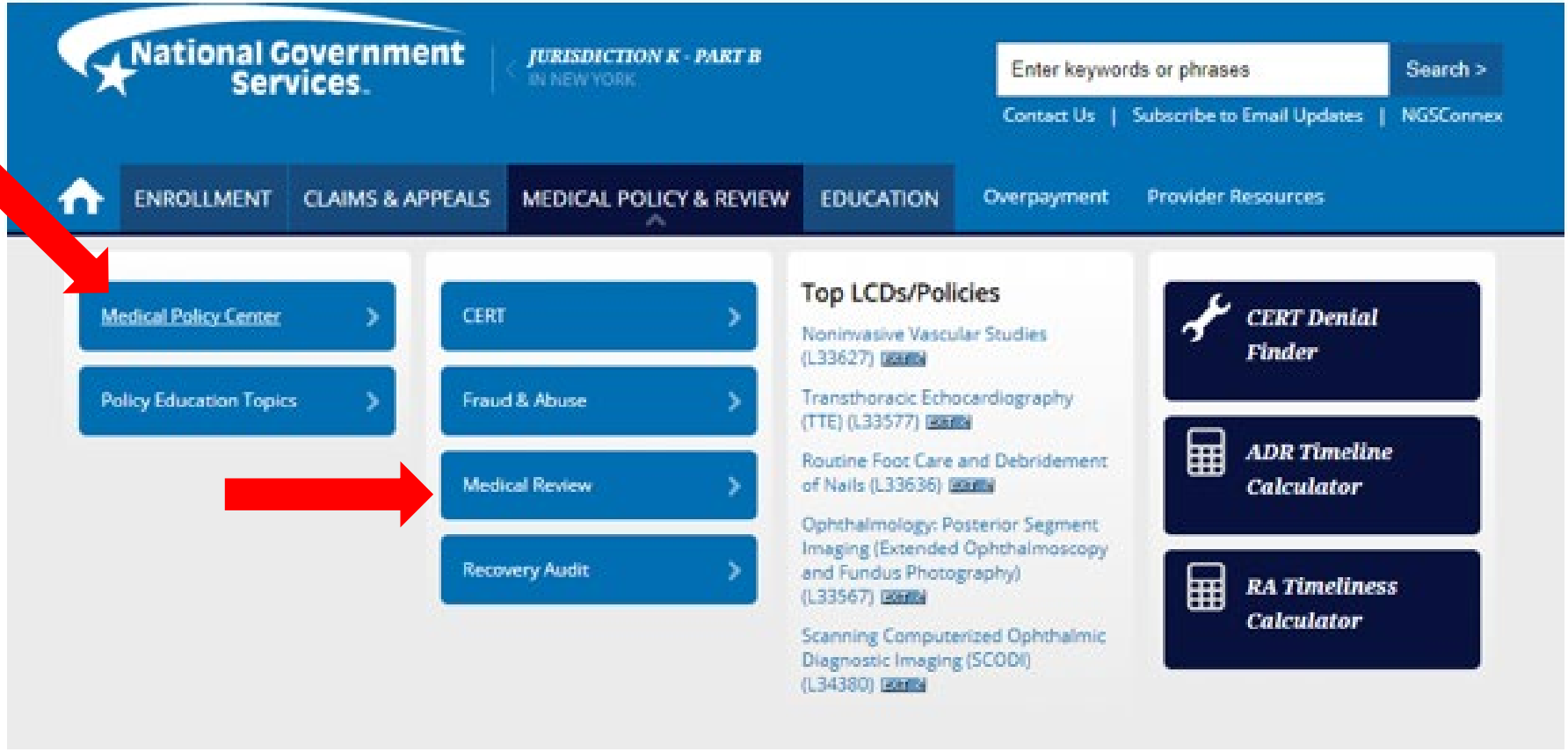
# Global Surgery Rules

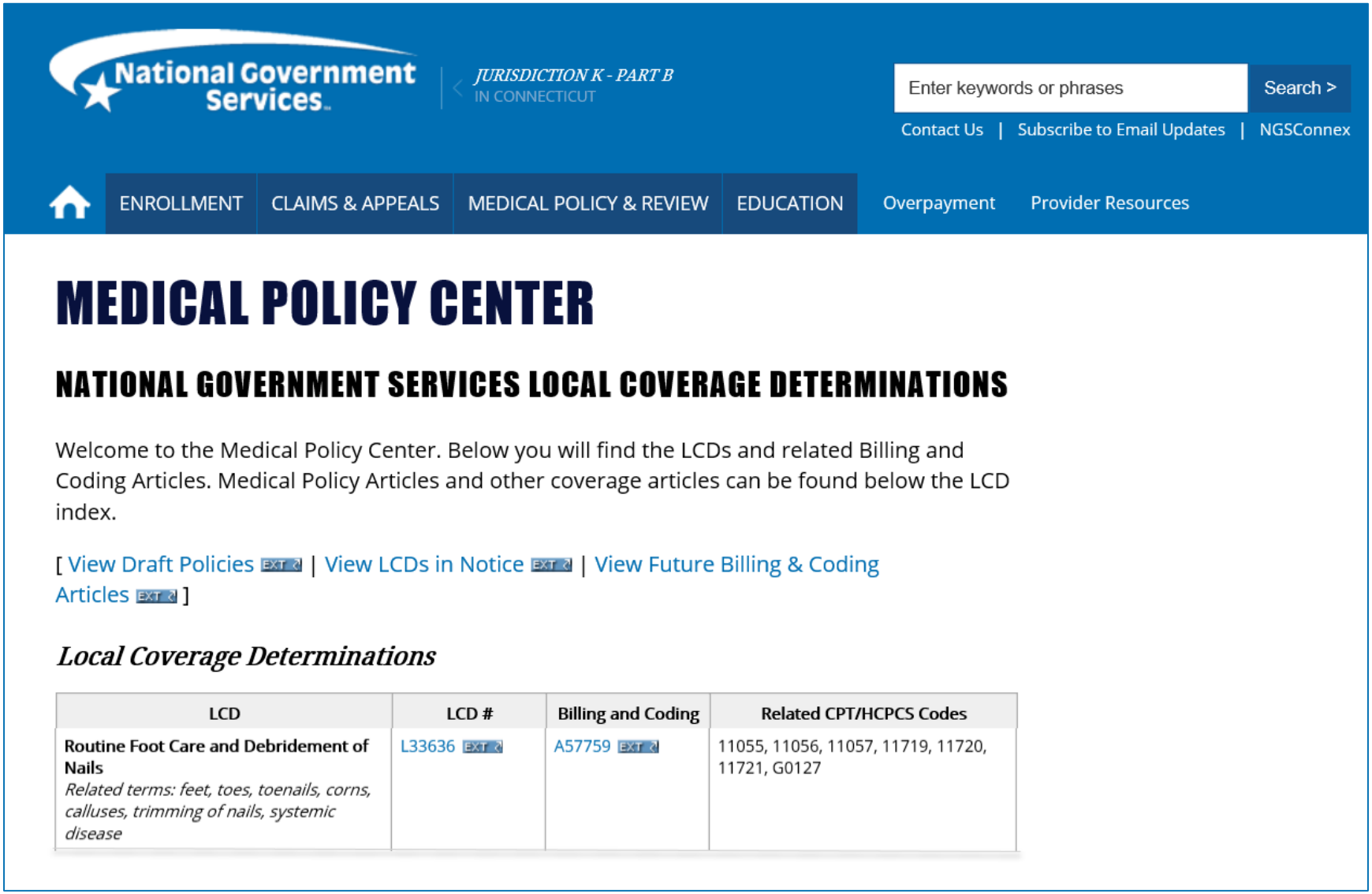
- The global surgery rules will apply to routine foot care procedure codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127
- As a result, an E/M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E/M service is a significant separately identifiable service, indicated by the use of modifier 25, and documented by medical records
- If the patient has evidence of neuropathy BUT no vascular impairment, the use of class findings modifiers is not necessary

# Medical Policy & Review



# Medical Policy & Review

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Welcome to the Medical Policy Center. Below you will find the LCDs and related Billing and Coding Articles. Medical Policy Articles and other coverage articles can be found below the LCD index.
[ View Draft Policies EXT | View LCDs in Notice EXT | View Future Billing & Coding Articles EXT ]
Local Coverage Determinations
LCD
LCD #
Billing and Coding
Related CPT/HCPCS Codes
Routine Foot Care and Debridement of Nails
Related terms: feet, toes, toenails, corns, calluses, trimming of nails, systemic disease
L33636 EXT
A57759 EXT
11055, 11056, 11057, 11719, 11720, 11721, G0127

# Medical Review Focus

- NGS Medical Review Department will be performing service specific post-payment reviews for a random selection of claims billed to Medicare Part A and B
- Providers are encouraged to review the Medical Review Focus Areas to learn about
  - Specific services being selected
  - Requested documentation
  - More details on these service specific post-payment reviews
- Medical Review Focus Areas


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POE Advisory Group

# EDUCATION

***Manuals***

- Additional Development Request Letter Guide
- Ambulance Billing Guide
- Anesthesia Billing Guide
- Companion Document for 5010 Transactions PDF
- EDI E-Signature User Guide
- General Information Guide
- IDTF Billing Guide
- Medicare Coverage of Chiropractic Services
- Medicare Part B 101 Manual
- Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P PDF
- Mental Health Billing Guide
- Ophthalmology/Optometry Billing Guide
- Outpatient Occupational and Physical Therapy Services Billing Guide
- Podiatry Billing Guide

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CMS.gov Internet-Only Manuals (IOMs)

New Provider Center

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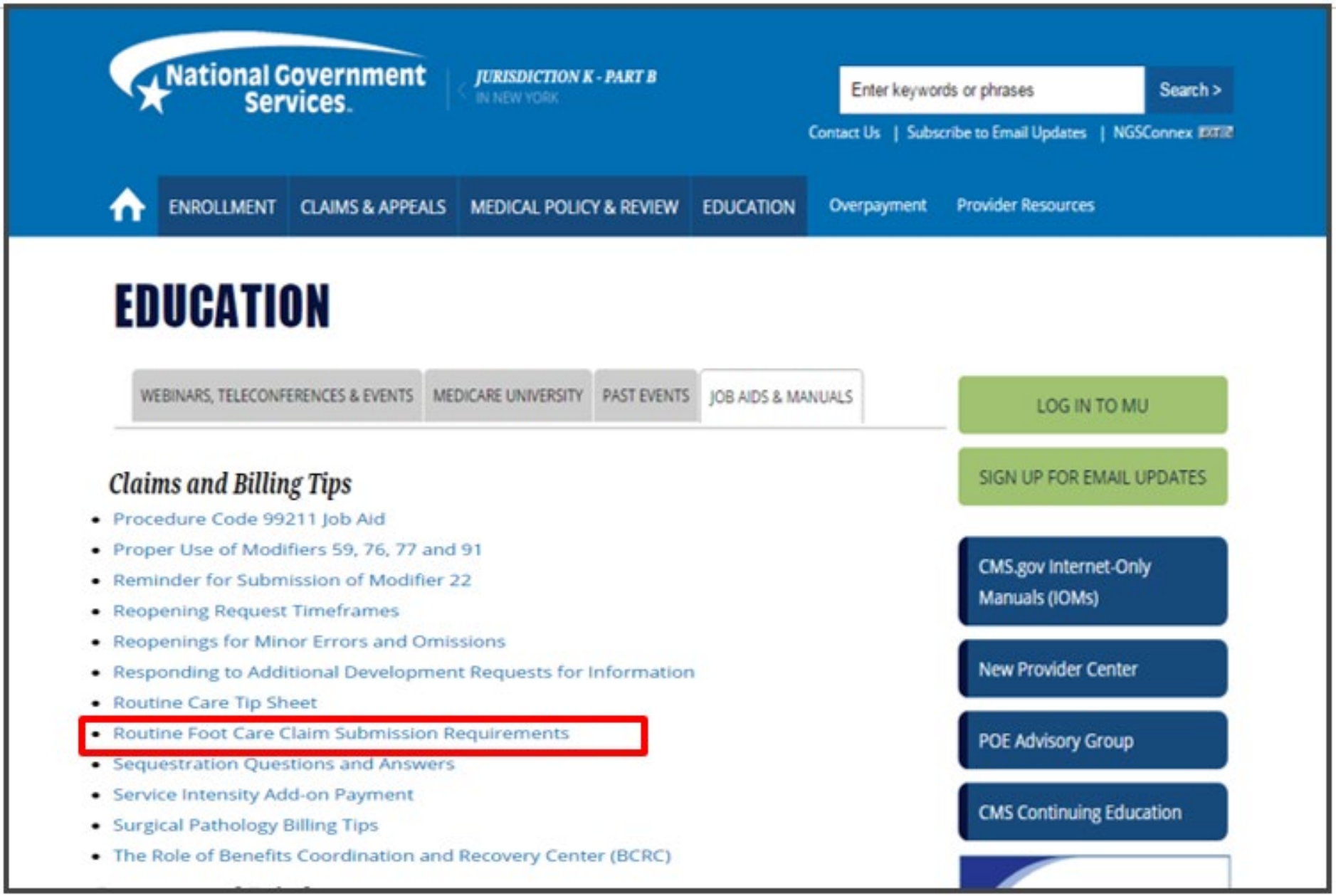
Official Information Health Care Professionals Can Trust

http://go.cms.gov/MLNGenInfo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Claims and Billing Tips
Procedure Code 99211 Job Aid
Proper Use of Modifiers 59, 76, 77 and 91
Reminder for Submission of Modifier 22
Reopening Request Timeframes
Reopenings for Minor Errors and Omissions
Responding to Additional Development Requests for Information
Routine Care Tip Sheet
Routine Foot Care Claim Submission Requirements
Sequestration Questions and Answers
Service Intensity Add-on Payment
Surgical Pathology Billing Tips
The Role of Benefits Coordination and Recovery Center (BCRC)
CMS.gov Internet-Only Manuals (IOMs)
New Provider Center
POE Advisory Group
CMS Continuing Education

# E/M and Modifier 25

- Use of modifier 25 indicates a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other therapeutic service
  - Patient's condition required significant, separately identifiable E/M service
  - Service was above/beyond usual pre/postoperative care associated with procedure
  - Service performed by same physician same day as procedure
- 25 modifier always follows E/M code
- E/M services are built into the fee components of minor surgical procedures

# Criteria For Proper Use of The 25 Modifier

- Both services must be significant, separate and distinct
- In general, Medicare considers E/M services provided on the day of a procedure to be part of the work of the procedure, and as such, does not make separate payment

# Appropriate Use of Modifier 25

**Example - Appropriate Use**

- A patient is scheduled by the podiatrist to take care of a fibrous hamartoma. During the visit, the patient indicates that he has had numbness and oozing from a lesion on his heel. The podiatrist evaluates the lesion, determines that it is a diabetic ulcer and treats it appropriately.
- In this case the heel lesion is considered a separate and significant service.

# Inappropriate Use of Modifier 25

**Example - Inappropriate Use**

- An established patient is seen in the office for debridement of mycotic nails. In the course of examining the feet prior to the procedure, Tinea Pedis is noted. Use of previously prescribed topical cream to treat the Tinea is recommended.
- In this case the Tinea was noted incidentally in the course of the evaluation of the mycotic nails and did not constitute a significant and separately identifiable E/M service above and beyond the usual pre and post care associated with nail debridement.

# National Correct Coding Initiative

| Column 1 | Column 2 | *= In existence prior to 1996 | Effective Date | Deletion Date *= no data | Modifier 0=not allowed 1=allowed 9=not applicable |
|---|---|---|---|---|---|
| A | B | C | D | E | F |
| 11720 | 99347 | | 19990101 | * | 1 |
| 11720 | 99348 | | 19990101 | * | 1 |
| 11720 | 99349 | | 19990101 | * | 1 |
| 11720 | 99350 | | 19990101 | * | 1 |
| 11720 | 99354 | | 19990101 | * | 1 |
| 11720 | 99355 | | 19990101 | * | 1 |
| 11720 | 99356 | | 19990101 | * | 1 |
| 11720 | 99357 | | 19990101 | * | 1 |
| 11720 | 99360 | | 19990101 | 19990101 | 9 |
| 11720 | 99374 | | 20130701 | * | 1 |
| 11720 | 99375 | | 19990101 | 19990101 | 9 |
| 11720 | 99375 | | 20130701 | * | 1 |
| 11720 | 99377 | | 20130701 | * | 1 |

# Modifier 59
# Distinct Procedural Service

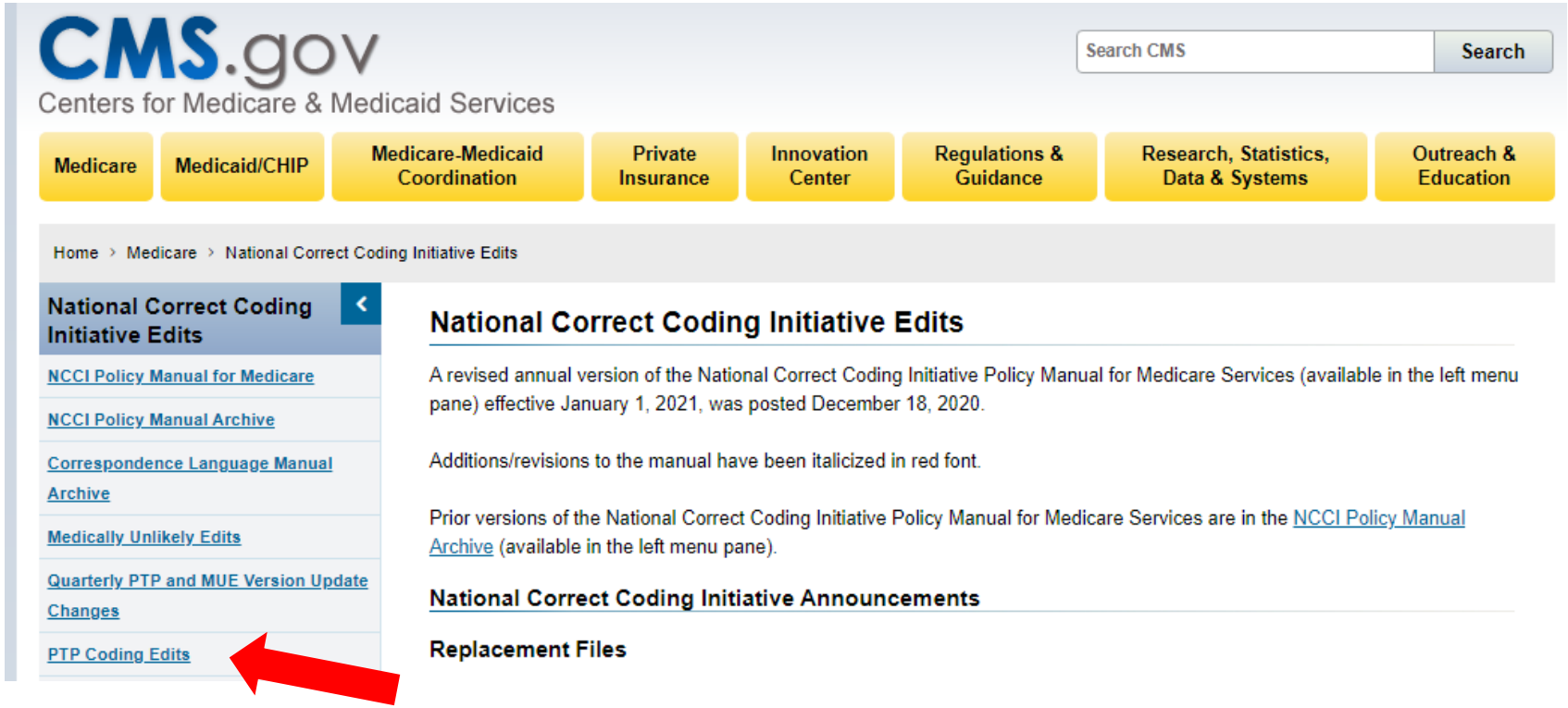
- Used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances
- Most widely used modifier
- Last modifier of choice
- Providers incorrectly consider this to be the modifier to bypass NCCI
- Associated with a significant amount of abuse cases and high levels of manual audit activities

# NCCI Example

| A | B | C | D | E | F |
|---|---|---|---|---|---|
| 11719 | 99451 | | 20190101 | * | 0 |
| 11719 | 99452 | | 20190101 | * | 0 |
| 11719 | 99455 | | 19990101 | 19990101 | 9 |
| 11719 | 99456 | | 19990101 | 19990101 | 9 |
| 11719 | 99483 | | 20180101 | * | 1 |
| 11719 | 99495 | | 20140101 | * | 1 |
| 11719 | 99496 | | 20140101 | * | 1 |
| 11719 | 99497 | | 20150101 | 20150101 | 9 |
| 11719 | C8950 | | 20060101 | 20061231 | 1 |
| 11719 | C8952 | | 20060101 | 20061231 | 1 |
| 11719 | G0127 | | 19980401 | * | 0 |
| 11719 | G0168 | | 20010701 | * | 1 |
| 11719 | G0345 | | 20050101 | 20051231 | 1 |
| 11719 | G0347 | | 20050101 | 20051231 | 1 |
| 11719 | G0351 | | 20050701 | 20051231 | 1 |
| 11719 | G0353 | | 20050701 | 20051231 | 1 |
| 11719 | G0354 | | 20050701 | 20051231 | 1 |
| 11719 | G0380 | | 20081001 | * | 1 |
| 11719 | G0381 | | 20081001 | * | 1 |

# Where to Find NCCI Edits

- PTP Coding Edits



# Billing Tips

- Procedure codes may be subject to NCCI edits or OPPS packaging edits, refer to CMS National Correct Coding Initiatives Edits and OPPS requirements prior to billing Medicare
- A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the *Social Security Act*

# Billing Tips

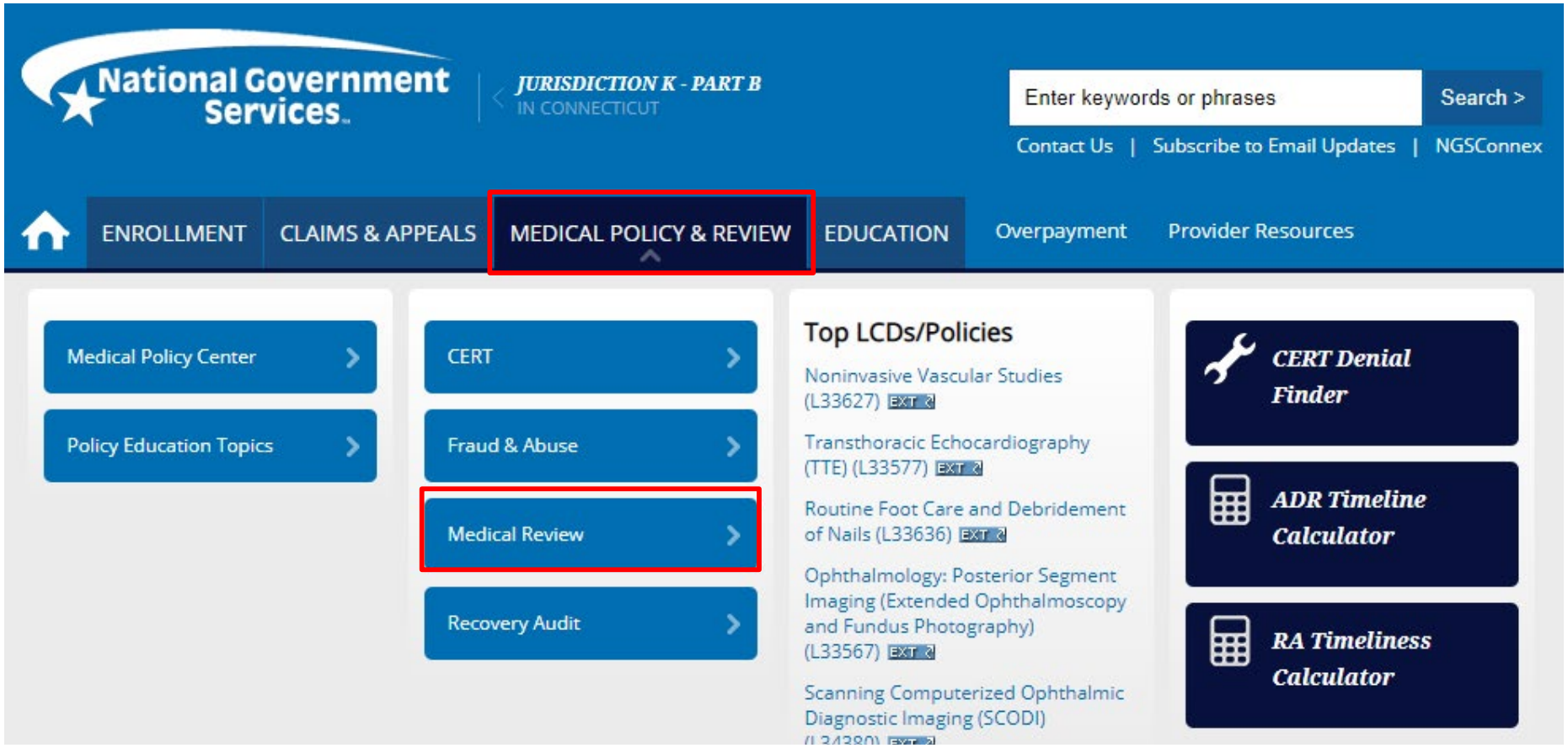
- ABN guidelines
  - An ABN may be used for services which are likely to be noncovered, whether for medical necessity or for other reasons
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 30, for complete instructions
  - MLN Educational Tool® *Advance Beneficiary Notice of Non-Coverage Interactive Tutorial - ICN MLN909183*

# Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

- You are not required to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit
- As a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability
- Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice
  - MLN Booklet® *Items & Services Not Covered Under Medicare Booklet ICN906765*

# Medical Review

# Medical Review



# Medical Review Focus Area

- Target Probe and Educate reviews continue to be on hold due to the Public Health Emergency related to COVID-19
- Medical Review Focus Area will perform service specific post-payment reviews for random selection of claims billed to Medicare Part A and Part B
  - Select Medical Policy & Review mega tab, then select Medical Review

# Part B Medical Review Newsletter

- New service that will provide you resources to stay up-to-date with Medical Review activities
- May include
  - Updates and News
  - Educational Resources
  - Helpful Tips and Reminders
  - Contact Information

# Resources

- Medical Policy Center - Part B
- LCD for Routine Foot Care and Debridement of Nails (L33636)
- Local Coverage Article for Billing and Coding: Routine Foot Care and Debridement of Nails (A57759)
- Local Coverage Article for Removal of Benign Skin Lesions (A54602)
- LCD Incision and Drainage (I & D) of Abscess of Skin, Subcutaneous and Accessory Structures (L33563)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Sections 30.6.1, 30.6.6, 30.6.14, 30.6.14.1 and 40.4
- Medicare Coverage Database
- NCCI | PTP Coding Edits | CMS

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?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