Podiatry Services: Routine Foot Care and Debridement of Nails

2/14/2023

national government SERVICES

NGS MU NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2446_11/1/2022

Today's Presenters

- Provider Outreach and Education Consultants
  - Michele Poulos
  - Lori Langevin

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

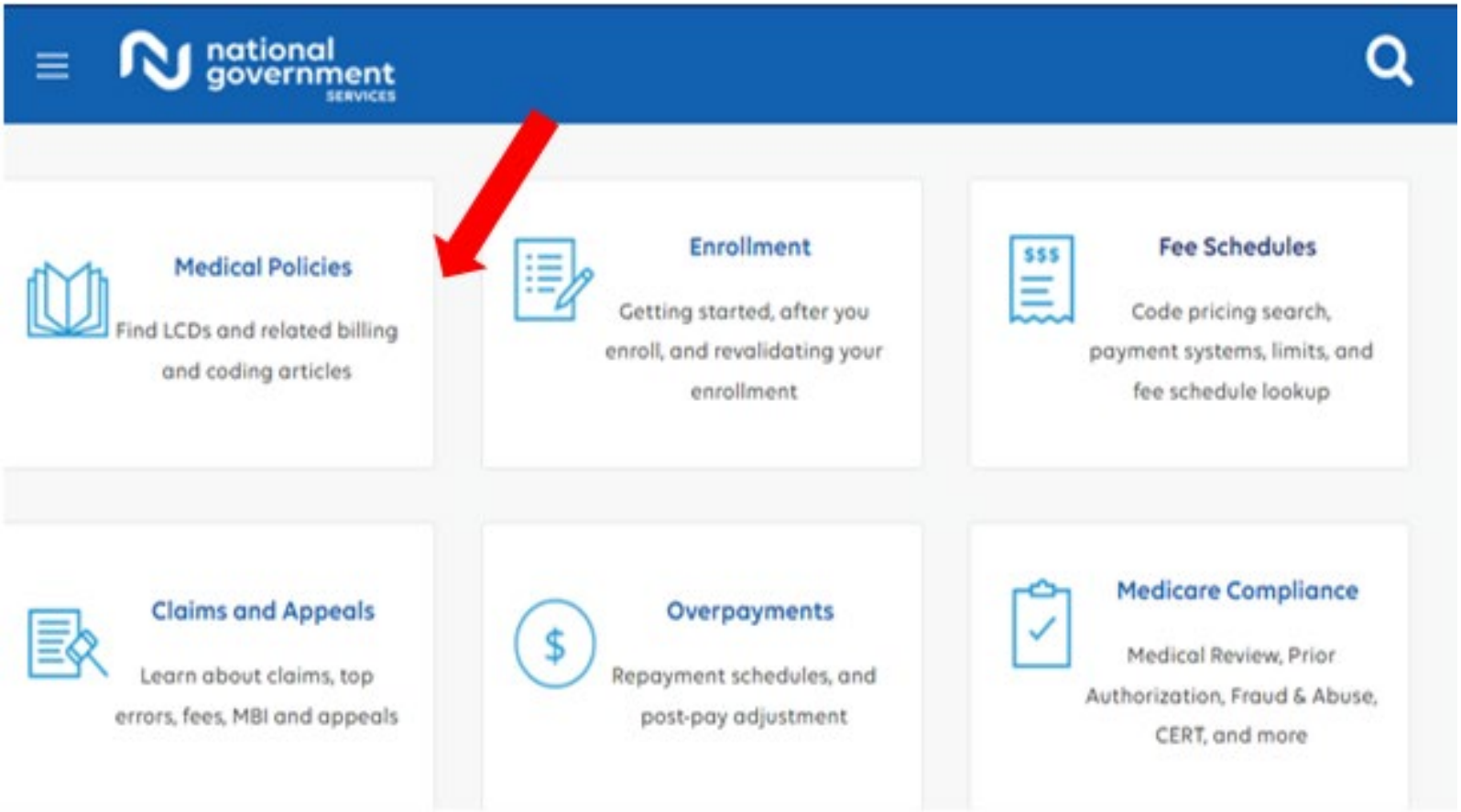
- To help podiatrists and their billing staff learn how to avoid requesting an appeal by providing education on how important it is to apply the LCD for Routine Foot Care and Debridement of Nails (L33636) to routine foot care claim submissions.

Agenda

- LCD for Routine Foot Care and Debridement of Nails (L33636) and Related Local Coverage Article (A57759)
- Billing Tips to Avoid Costly Appeals
- E/M and Modifier 25
- NCCI
- Medical Review
- Resources

LCD for Routine Foot Care and Debridement of Nails (L33636) & Related Local Coverage Article (A57759)

Medical Policies



Medical Policies - LCDs

Medical Policies - LCDs

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below.

Please note: There are many procedures for which NGS does not have an LCD/Billing and Coding Article. If your search does not return any coverage documents, then NGS does not have a local coverage statement for that procedure.

For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | Medical Policy Articles

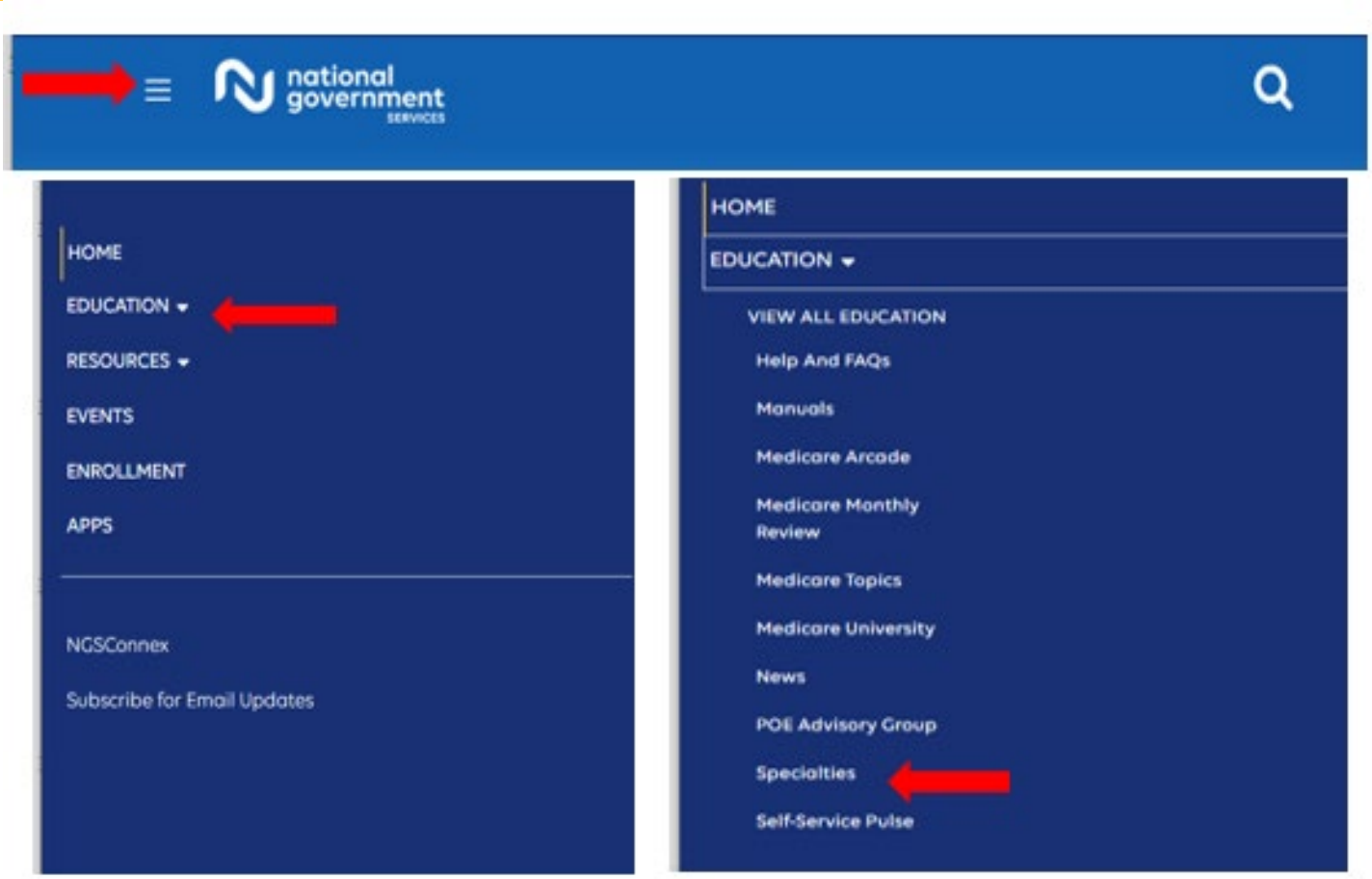
Local Coverage Determinations

Routine Foot Care and Debridement of Nails *Related terms: feet, toes, toenails, corns, calluses, trimming of nails, systemic disease*	L33636	A57759	11055, 11056, 11057, 11719, 11720, 11721, G0127

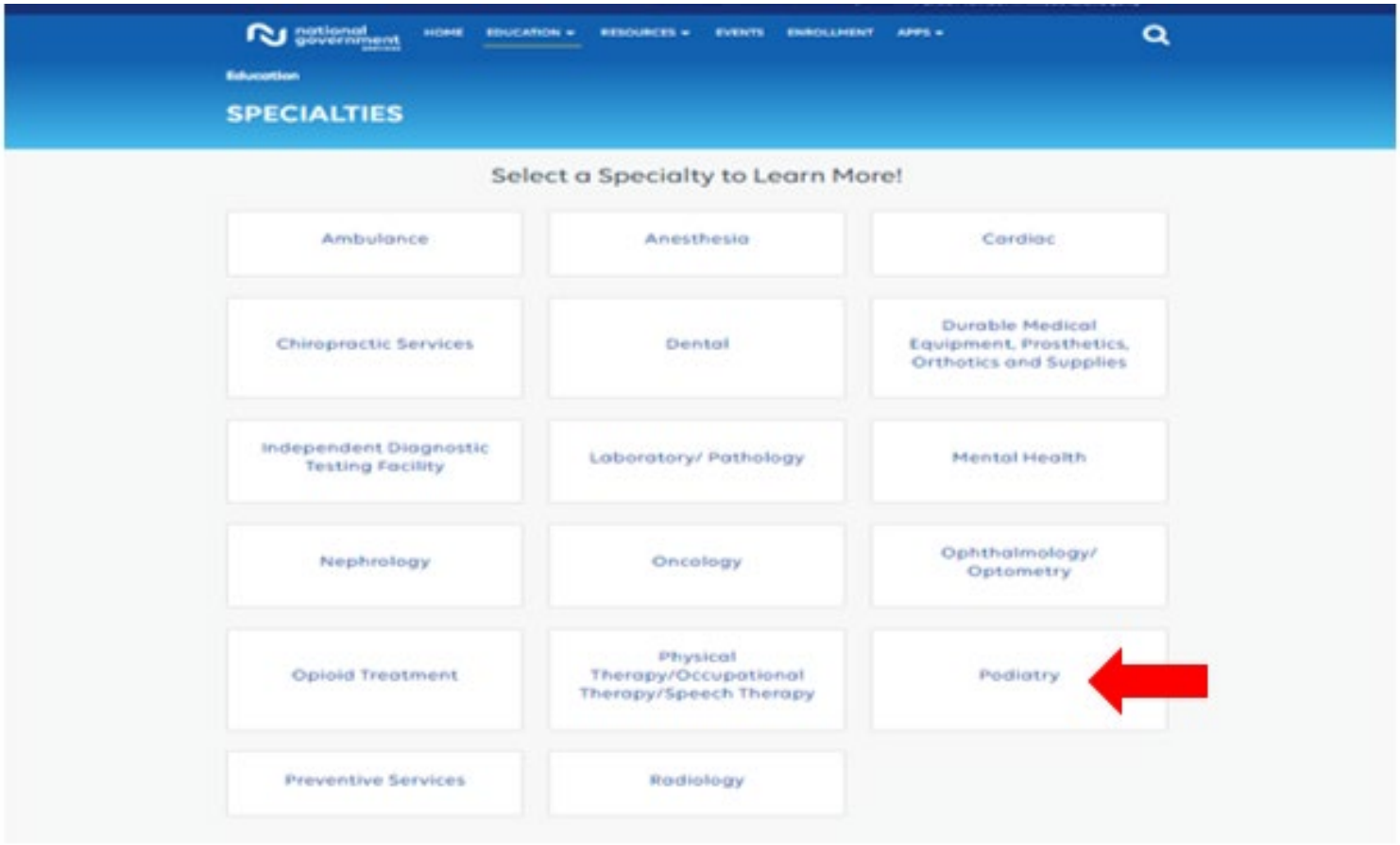
national government SERVICES

NGS MU

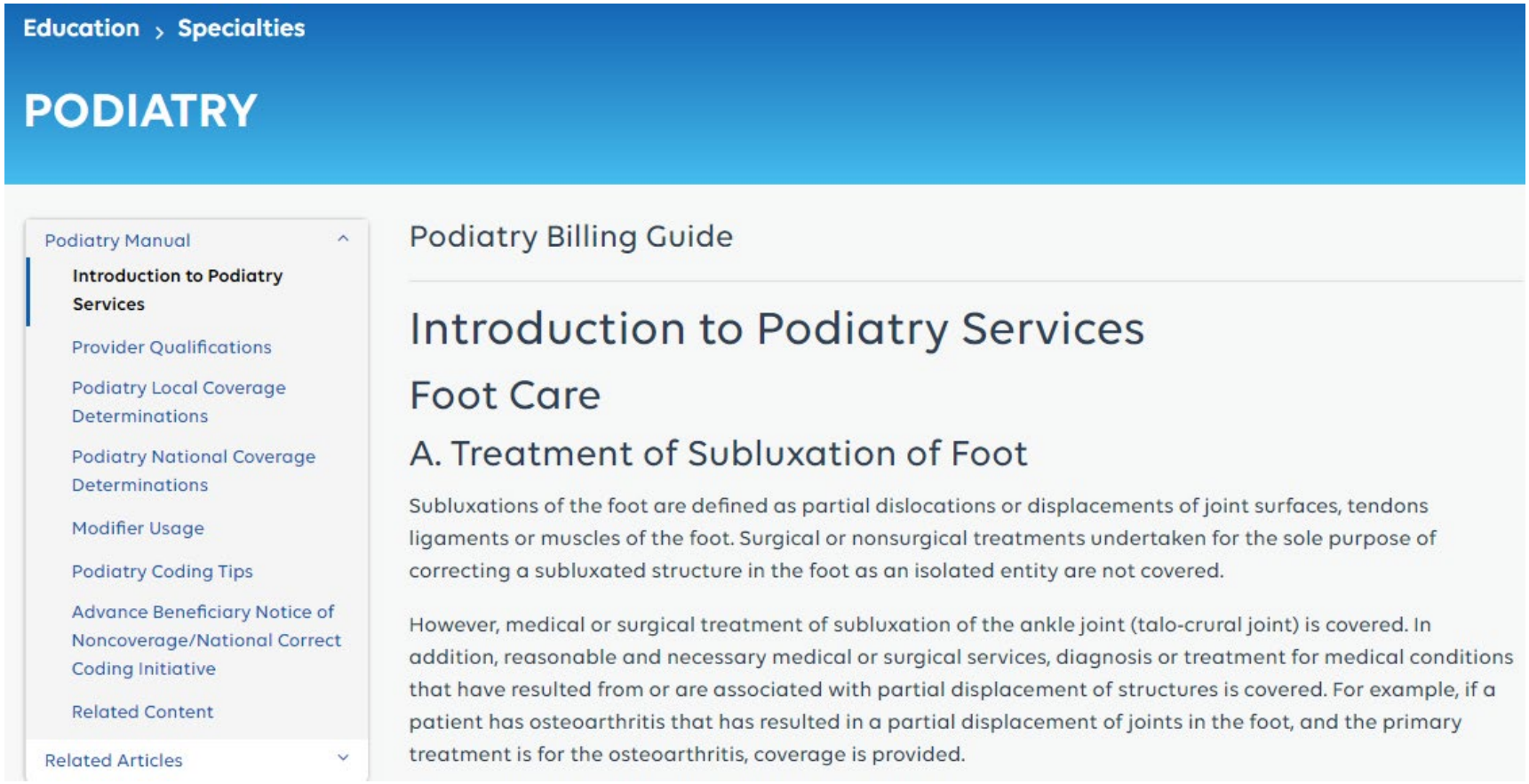
Podiatry Billing Guide



Podiatry Billing Guide



Podiatry Billing Guide



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
  - Clinical mycosis of nail
  - Marked limitation of ambulation, pain and/or secondary infection resulting from thickening/dystrophy of nail plate
- Nonambulatory patients
  - Clinical mycosis of nail
  - 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 to Avoid Costly Appeals

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)** 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 **primary** physician
  - The approximate date when the beneficiary was last seen by the **MD/DO** 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

Billing Tips

- Procedure codes may be subject to NCCI edits, prior to billing Medicare refer to CMS National Correct Coding Initiatives Edits
- 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
- The diagnosis code(s) must best describe the patient's condition for which the service was performed
- For diagnostic tests report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported

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*

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, 4th digit)
- Documentation of coexisting systemic illness should be maintained

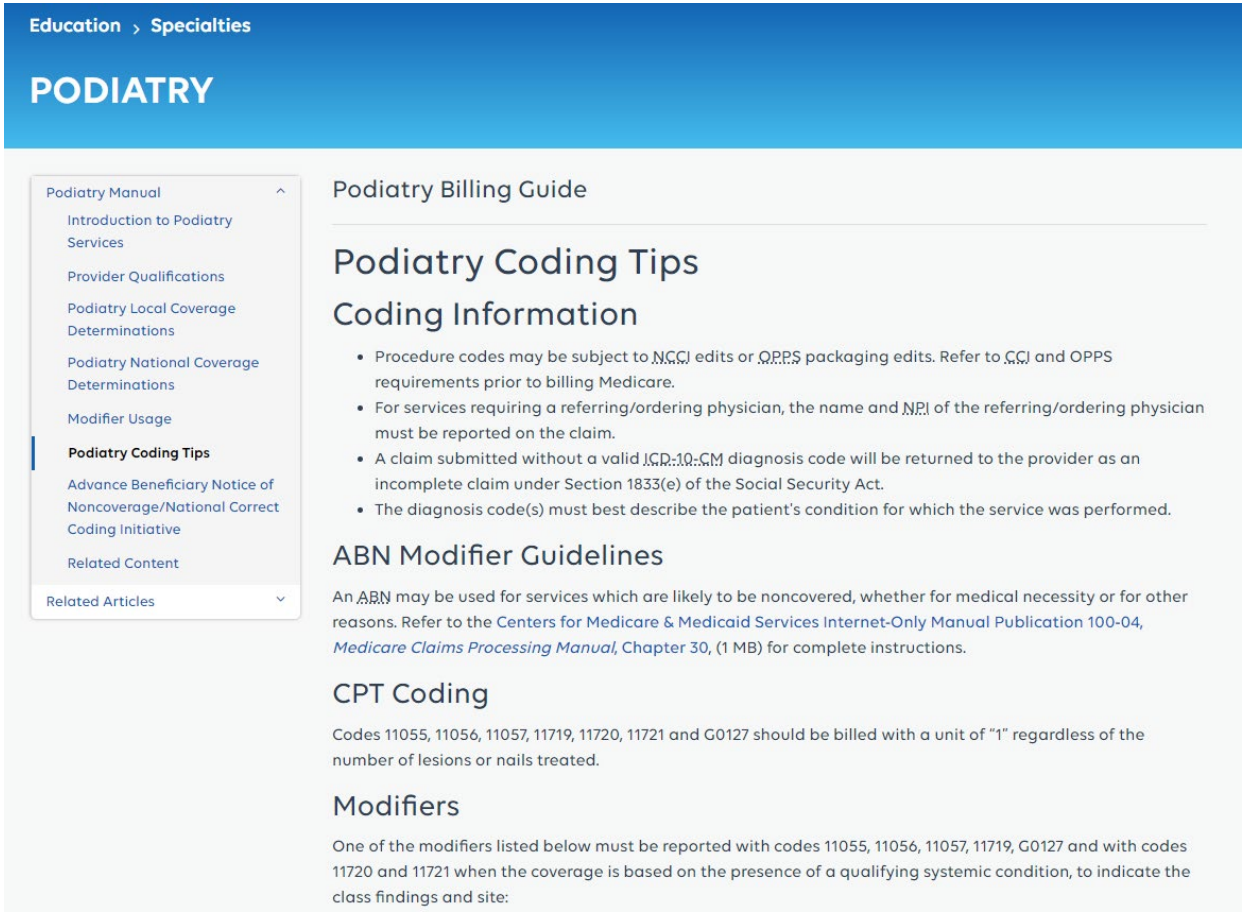
Utilization Guidelines

- 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

Podiatry Coding Tips



Education › Specialties

PODIATRY

Podiatry Manual
- Introduction to Podiatry Services
- Provider Qualifications
- Podiatry Local Coverage Determinations
- Podiatry National Coverage Determinations
- Modifier Usage
- **Podiatry Coding Tips**
- Advance Beneficiary Notice of Noncoverage/National Correct Coding Initiative
- Related Content

Related Articles

Podiatry Billing Guide

Podiatry Coding Tips

Coding Information

- Procedure codes may be subject to NCCI edits or OPPS packaging edits. Refer to CCI and OPPS requirements prior to billing Medicare.
- For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.
- 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.
- The diagnosis code(s) must best describe the patient's condition for which the service was performed.

ABN Modifier Guidelines

An ABN may be used for services which are likely to be noncovered, whether for medical necessity or for other reasons. Refer to the Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, (1 MB) for complete instructions.

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.

Modifiers

One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127 and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, to indicate the class findings and site:

How Providers Can Avoid Costly Appeals

- Verify procedure code (s) are appropriate based on medical records
- Use modifiers when applicable
- Number of service(s) and billed amount for each service is correct
- Date last seen by primary physician
  - The approximate date when the beneficiary was last seen by the MD/DO 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
  - If this information is not entered on the CMS-1500 claim form/electronic equivalent, it is considered "missing information" and the claim will be returned as unprocessable which assigns responsibility to the provider (CO)
- Use the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim when needed
- Verify primary payer data

E/M and Modifier 25

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 they've had numbness and oozing from a lesion on the 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.

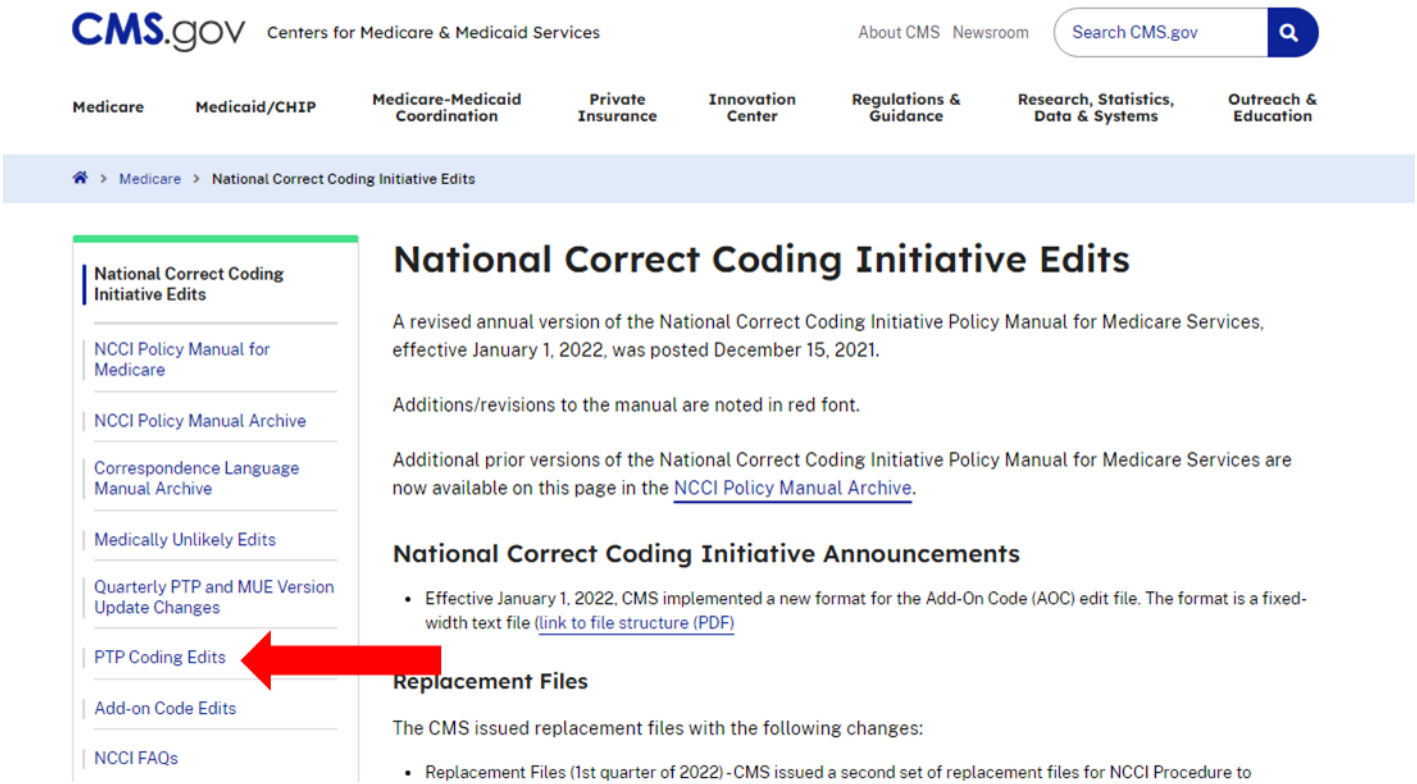
Inappropriate Use of Modifier 25

- **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.

NCCI

Where to Find NCCI Edits

- PTP Coding Edits | CMS



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

National Correct Coding Initiative

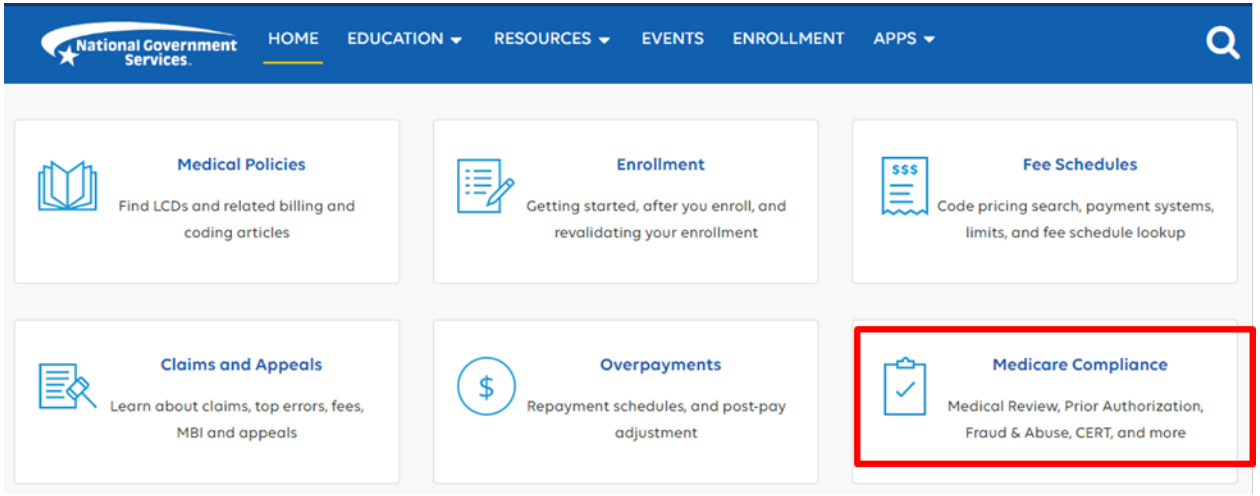
Column 1	Column 2	*= In existence prior to 1996	Effective Date	Deletion Date *= no data	Modifier 0=not allowed 1=allowed 9=not applicable
A	B	C	D	E	F
11719	G0127		19980401	*	0
11719	G0168		20010701	*	1

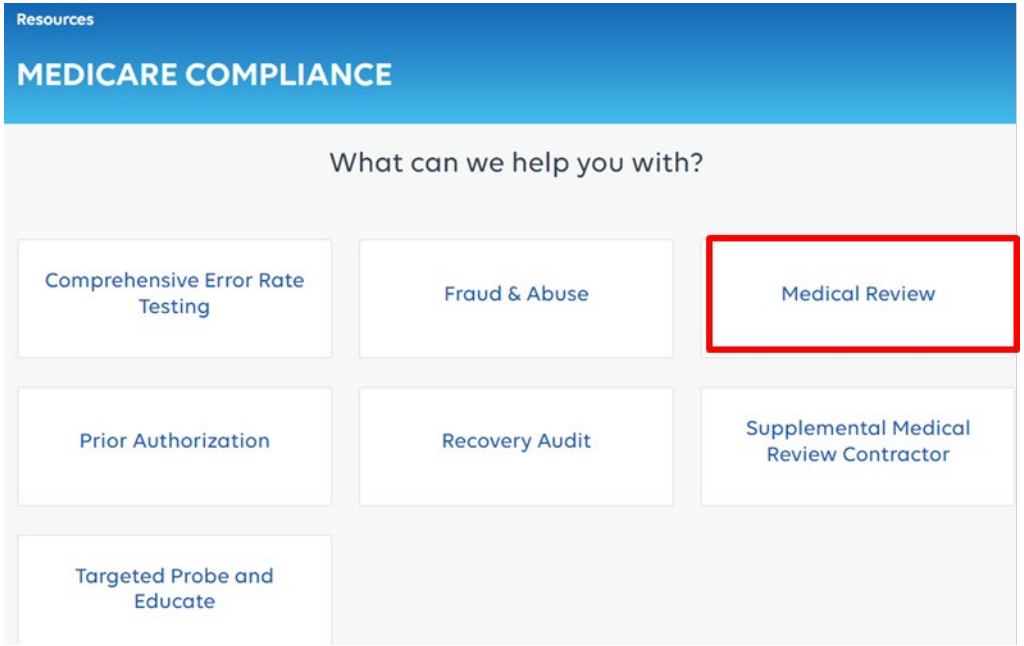
Modifier 59
Distinct Procedural Service

- 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

Medical Review

Medical Review





Medical Review

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
- PTP Coding Edits | CMS

Thank You!

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

FOLLOW US