

Podiatry Services - Routine Foot Care and Debridement of Nails

11/30/2023

Closed Captioning: Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.

Today's Presenters



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



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Recording

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

Objective

To assist providers and their billing staff to have a better understanding of the routine foot care and debridement of nails local coverage determination and the related coverage article.



Agenda

Routine Foot Care LCD and Related Article

Billing Tips

E/M Modifiers

NCCI

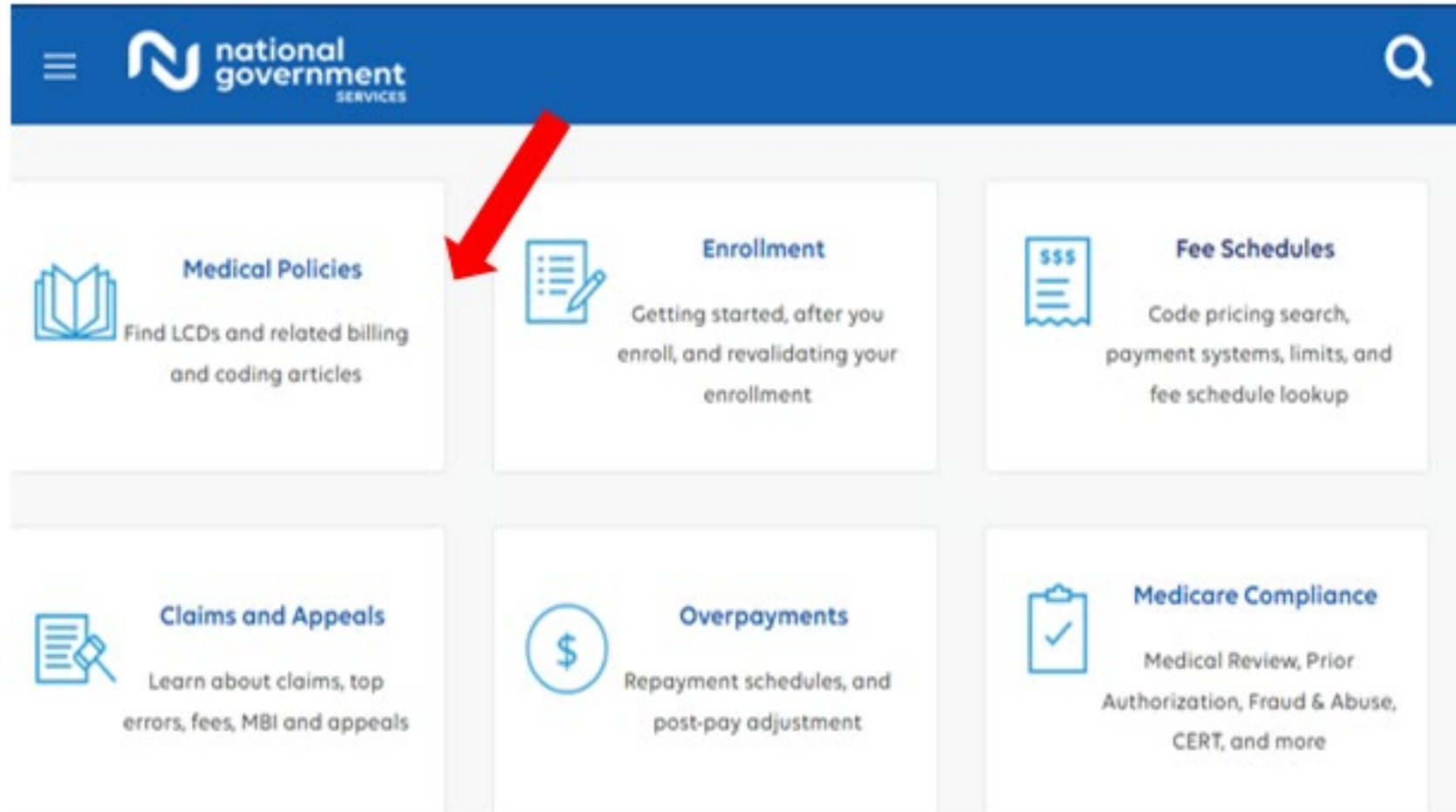
Medical Review

Test Your Knowledge

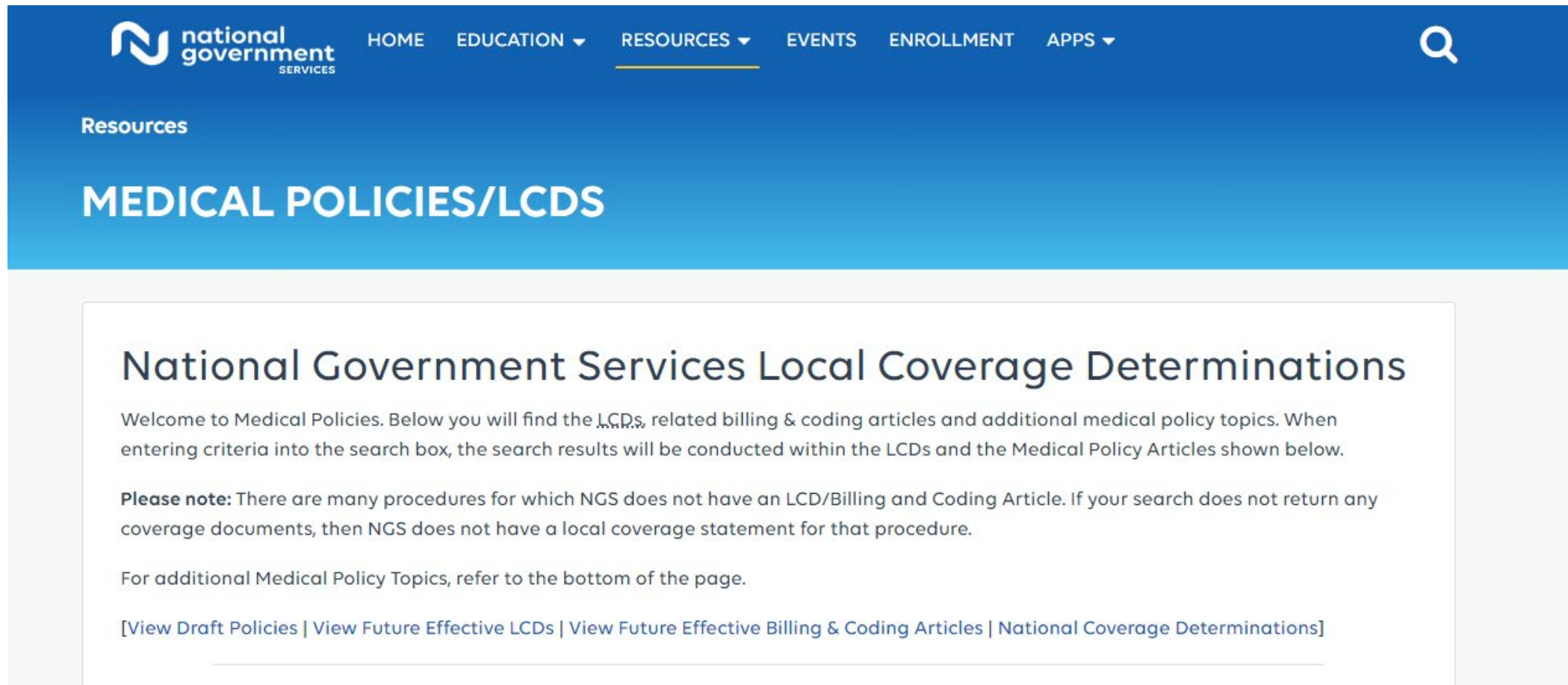
Resources

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

Medical Policies



Medical Policies - LCDs



The screenshot shows the top navigation bar of the National Government Services website. The logo is on the left, followed by links for HOME, EDUCATION, RESOURCES (which is underlined), EVENTS, ENROLLMENT, and APPS. A search icon is on the right. Below the navigation bar, the word "Resources" is displayed. The main heading "MEDICAL POLICIES/LCDS" is in large, bold, white letters on a blue background. The content area below has a light gray background and contains the title "National Government Services Local Coverage Determinations". The text welcomes users to Medical Policies and explains the search function. A "Please note" section states that NGS does not have an LCD/Billing and Coding Article for all procedures. A link to "View Draft Policies" is provided. At the bottom, there are links to "View Future Effective LCDs", "View Future Effective Billing & Coding Articles", and "National Coverage Determinations".

Resources

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](#)

Medical Policies

How to Search for 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.

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



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

Podiatry Billing Guide

Home Page

The screenshot shows the National Government Services website. The top navigation bar includes links for 'Contact Us', 'NGSConnex', 'Subscribe for Email Updates', and 'Part B Provider in New York (JK)'. The main navigation bar features 'HOME', 'EDUCATION' (highlighted with a red box), 'RESOURCES', 'EVENTS', 'ENROLLMENT', and 'APPS'. A search icon is on the right. The 'EDUCATION' dropdown menu is open, showing 'VIEW ALL EDUCATION' at the top, followed by two columns of links: 'Help And FAQs', 'Medicare Arcade', 'Medicare Topics', 'News', 'Self-Service Pulse' on the left; and 'Manuals and Guides', 'Medicare Monthly Review', 'Medicare University', 'POE Advisory Group', 'Specialties' on the right. A red arrow points to 'Specialties'. Below the menu, there are four main content areas: 'Medical Policies' (with an icon of an open book and text 'Find LCDs and related coding articles'), 'Claims and Appeals' (with an icon of a document and magnifying glass and text 'Learn about claims, top errors, fees, MBI and appeals'), 'Overpayments' (with a dollar sign icon and text 'Repayment schedules, and post-pay adjustment'), and 'Fee Schedules' (with text 'Find pricing search, payment systems, limits, and fee schedule lookup'). At the bottom right, there is a 'Medicare Compliance' section (with a clipboard icon and text 'Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more').

Podiatry Billing Guide

Select Specialty

Select a Specialty to Learn More!

Ambulance	Anesthesia	Cardiac
Chiropractic Services	Dental	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
Independent Diagnostic Testing Facility	Laboratory/ Pathology	Mental Health
Nephrology	Oncology	Ophthalmology/ Optometry
Opioid Treatment	Physical Therapy/ Occupational Therapy/ Speech Therapy	Podiatry

Podiatry Billing Guide

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 v

Podiatry Billing Guide

Introduction to Podiatry Services Foot Care

A. Treatment of Subluxation of Foot

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons ligaments or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

However, medical or surgical treatment of subluxation of the ankle joint (talo-crural joint) is covered. In addition, reasonable and necessary medical or surgical services, diagnosis or treatment for medical conditions that have resulted from or are associated with partial displacement of structures is covered. For example, if a patient has osteoarthritis that has resulted in a partial displacement of joints in the foot, and the primary treatment is for the osteoarthritis, coverage is provided.

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
- 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 - Systemic Disease

- 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 - Peripheral Neuropathy

- 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 - Warts

- 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

Mycotic Nails

- Treatment of mycotic nails may be covered under the exceptions to the routine foot care exclusion
- The class findings, or the presence of qualifying systemic illnesses causing a peripheral neuropathy, must be present and grant the presumption of coverage
- In the absence of a systemic condition, the following criteria must be met
 - In the case of ambulatory patients there exists
 - ✓ Clinical evidence of mycosis of the toenail, and
 - ✓ Marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate
 - In the case of nonambulatory patients there exists
 - ✓ Clinical evidence of mycosis of the toenail, and the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate

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

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

- Two Class B findings are needed
 - 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

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

■ 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

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

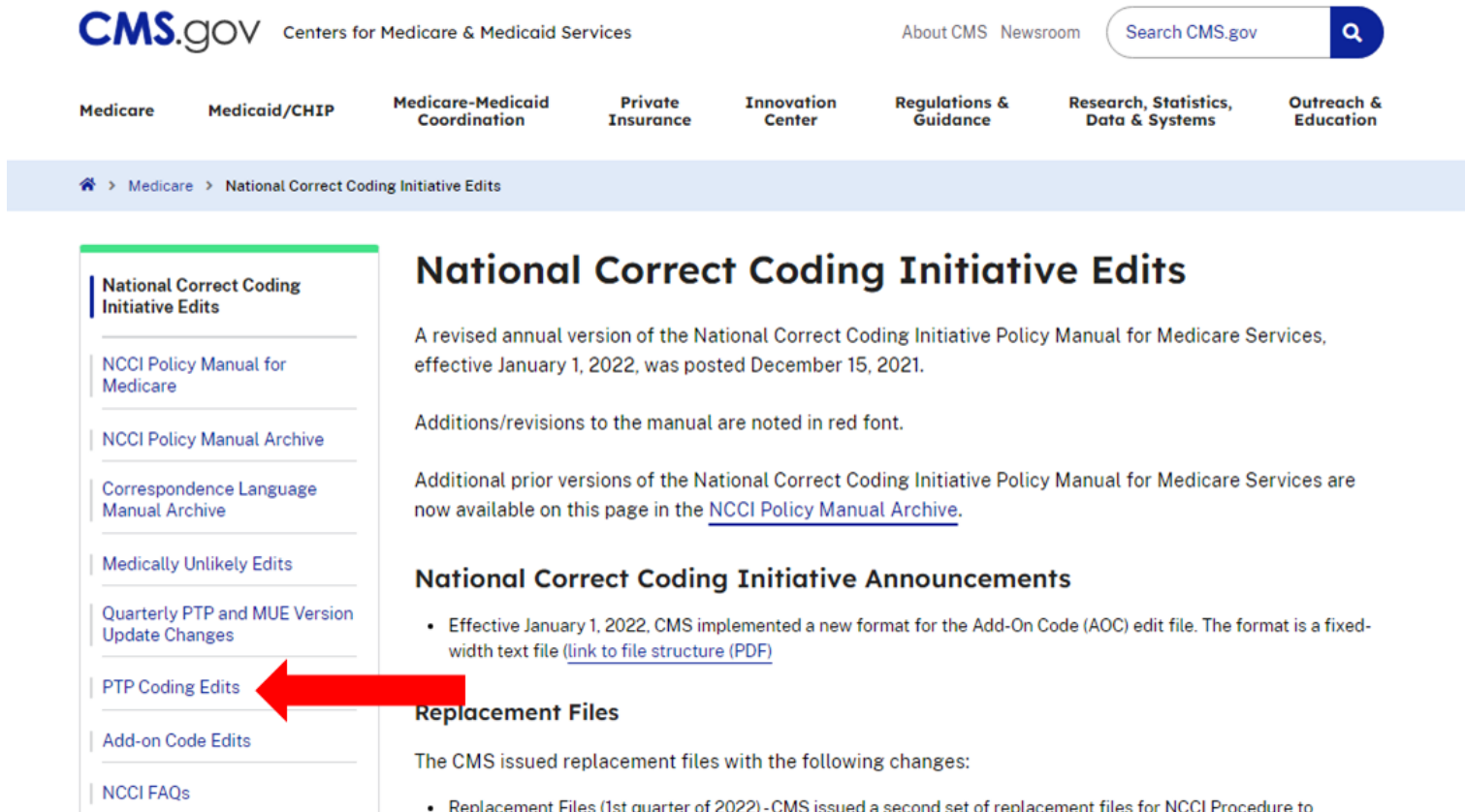
Example - Inappropriate Use

- 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](#)



The screenshot shows the CMS.gov website. The header includes the CMS.gov logo, the text "Centers for Medicare & Medicaid Services", and navigation links for "About CMS", "Newsroom", and a search bar. Below the header is a horizontal menu with links for "Medicare", "Medicaid/CHIP", "Medicare-Medicaid Coordination", "Private Insurance", "Innovation Center", "Regulations & Guidance", "Research, Statistics, Data & Systems", and "Outreach & Education".

The breadcrumb trail reads: Home > Medicare > National Correct Coding Initiative Edits.

The main content area is titled "National Correct Coding Initiative Edits". It contains the following text:

A revised annual version of the National Correct Coding Initiative Policy Manual for Medicare Services, effective January 1, 2022, was posted December 15, 2021.

Additions/revisions to the manual are noted in red font.

Additional prior versions of the National Correct Coding Initiative Policy Manual for Medicare Services are now available on this page in the [NCCI Policy Manual Archive](#).

The left sidebar contains a list of links: "National Correct Coding Initiative Edits", "NCCI Policy Manual for Medicare", "NCCI Policy Manual Archive", "Correspondence Language Manual Archive", "Medically Unlikely Edits", "Quarterly PTP and MUE Version Update Changes", "PTP Coding Edits", "Add-on Code Edits", and "NCCI FAQs". A red arrow points to the "PTP Coding Edits" link.

Below the main text, there is a section titled "National Correct Coding Initiative Announcements" with a bullet point: "Effective January 1, 2022, CMS implemented a new format for the Add-On Code (AOC) edit file. The format is a fixed-width text file ([link to file structure \(PDF\)](#))".

Below that is a section titled "Replacement Files" with the text: "The CMS issued replacement files with the following changes:" and a bullet point: "Replacement Files (1st quarter of 2022) -CMS issued a second set of replacement files for NCCI Procedure to".

National Correct Coding Initiative

Example 1

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	N/A	19990101	*	1
11720	99348	N/A	19990101	*	1
11720	99349	N/A	19990101	*	1
11720	99350	N/A	19990101	*	1
11720	99354	N/A	19990101	*	1
11720	99355	N/A	19990101	*	1
11720	99356	N/A	19990101	*	1
11720	99357	N/A	19990101	*	1

National Correct Coding Initiative

Example 2

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	N/A	19980401	*	0
11719	G0168	N/A	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

national government SERVICES


HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾






Medical Policies/LCDs

Find LCDs and related billing and coding articles




Enrollment

Getting started, after you enroll, and revalidating your enrollment




Fee Schedules

Code pricing search, payment systems, limits, and fee schedule lookup




Claims and Appeals

Learn about claims, top errors, fees, MBI and appeals



Overpayments

Repayment schedules, and post-pay adjustment



Medicare Compliance

Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

Resources

MEDICARE COMPLIANCE

What can we help you with?

Comprehensive Error Rate Testing

Fraud & Abuse


Medical Review

Prior Authorization

Recovery Audit

Supplemental Medical Review Contractor

Targeted Probe and Educate

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NGSMU | 50

Medical Review Process

The screenshot displays the National Government Services website. The top navigation bar includes links for HOME, EDUCATION, RESOURCES (highlighted), EVENTS, ENROLLMENT, and APPS. A search icon is located on the right. Below the navigation bar, the breadcrumb trail reads 'Resources > Medicare Compliance'. The main heading is 'MEDICAL REVIEW'. On the left, a sidebar menu shows 'Medical Review' with a sub-item 'NGS Medical Review Process' selected. The main content area is titled 'NGS Medical Review Process' and contains two paragraphs of text. The first paragraph explains that Medicare contractors, like National Government Services, operate the medical review program to prevent improper payments and protect the Medicare Trust Fund. The second paragraph describes how medical review identifies errors through claim analysis and/or medical record review activities. A third paragraph provides information about the TPE program, directing users to the TPE Home Page and Best Practices for a Successful Targeted Probe and Educate article. On the right, a 'Helpful Resources' section lists 'Targeted Probe and Educate Manual', 'The preferred method to submit Medical Records is NGSConnex', 'NGSConnex', 'NGSConnex User Guide', and a link to 'Visit our Contact Us page for other methods of submission.'

national government SERVICES

HOME EDUCATION ▼ **RESOURCES ▼** EVENTS ENROLLMENT APPS ▼

Resources > Medicare Compliance

MEDICAL REVIEW

Medical Review ^

NGS Medical Review Process

NGS Medical Review Process

Medicare contractors, like National Government Services, operate the medical review program to prevent improper payments and protect the Medicare Trust Fund. Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing and medical necessity requirements.

Medical review identifies errors through claim analysis and/or medical record review activities. Contractors use this information to help ensure they provide proper Medicare payments (and recover any improper payments if the claim was already paid). Contractors also offer education to help ensure future compliance. A Medicare contractor may use any necessary information to make a claim review determination, including any documentation submitted with the claim or through an additional documentation request.

If you would like information about our TPE program, please visit the [TPE Home Page](#) and review our [Best Practices for a Successful Targeted Probe and Educate](#) article.

Helpful Resources

[Targeted Probe and Educate Manual](#)

The preferred method to submit Medical Records is NGSConnex:

[NGSConnex](#)

[NGSConnex User Guide](#)

Visit our [Contact Us](#) page for other methods of submission.

The background is a solid dark blue. On the right side, there are large, overlapping, semi-transparent blue geometric shapes, including a large 'S' or 'R' curve and a triangular shape. In the bottom-left corner, there is a pattern of small, light blue dots arranged in a grid-like fashion.

Test Your Knowledge

Test Your Knowledge One and Two

1. Routine foot care is generally not covered for the following
 - a. Cutting or removal of corns and calluses
 - b. Clipping, trimming, or debridement of nails, including debridement of mycotic nails
 - c. Shaving, paring, cutting or removal of keratoma, tyloma, and heloma
 - d. Nondefinitive simple, palliative treatments
 - e. All of these
2. Treatment of mycotic nails may be covered under the exceptions to the routine foot care exclusion.
 - a. True
 - b. False

Test Your Knowledge Three and Four

3. 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.
 - a. True
 - b. False
4. Procedure codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127 should be billed with the number of units that match the number of lesions or nails treated.
 - a. True
 - b. False

Test Your Knowledge Five and Six

5. Modifier Q7, Q8 or Q9 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 EXCEPT where the patient has evidence of neuropathy, but no vascular impairment, for which class findings modifiers are not required.
 - a. True
 - b. False
6. For ICD-10-CM codes which fall under the active care requirement, the approximate date when the beneficiary was last seen by the M.D. or D.O. who diagnosed the complicating condition (attending physician) must be reported in an eight-digit (MM/DD/YYYY) format in Item 19 of the CMS-1500 claim form or the electronic equivalent.
 - a. True
 - b. False

Test Your Knowledge Seven and Eight

7. The treatment of warts on the foot is never covered.
 - a. True
 - b. False

8. Routine foot care services are considered medically necessary once every 60 days.
 - a. True
 - b. False

Test Your Knowledge Nine and Ten

9. Which of the following metabolic, neurologic, and peripheral vascular diseases most commonly represent the underlying conditions that might justify coverage for routine foot care?
 - a. Diabetes mellitus
 - b. Arteriosclerosis obliterans
 - c. Buerger's disease
 - d. Peripheral neuropathies involving the feet
 - e. All of these
10. The global surgery rules do not apply to routine foot care procedure codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127.
 - a. True
 - b. False

“What if” and Scenario Questions

- MACs cannot provide a definitive answer on whether Medicare would make payment for a service
 - MACs can only provide information on Medicare rules and regulations, the final determination is based on information contained in an individual patient’s medical record
- MACs may not provide a preliminary medical review determination based on snippets of information or documentation
 - Final determination of payment is made after the submission of the claim and any medical review that may be performed
 - MACs will not grant prior approval or affirm a provider’s individual practice’s procedures, coding or documentation are sufficient to meet all Medicare guidelines
- Remember, providers are responsible for determining the correct diagnostic and procedural coding for the services furnished to Medicare patients
- After reviewing Medicare guidelines, providers, compliance, audit and/or billing staff can find more information on coding resources in [CMS IOM Publication 100-09, Medicare Administrative Contractor \(MAC\) Beneficiary and Provider Communications Manual, Chapter 6, Section 30.3.1](#)

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](#)
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Questions?

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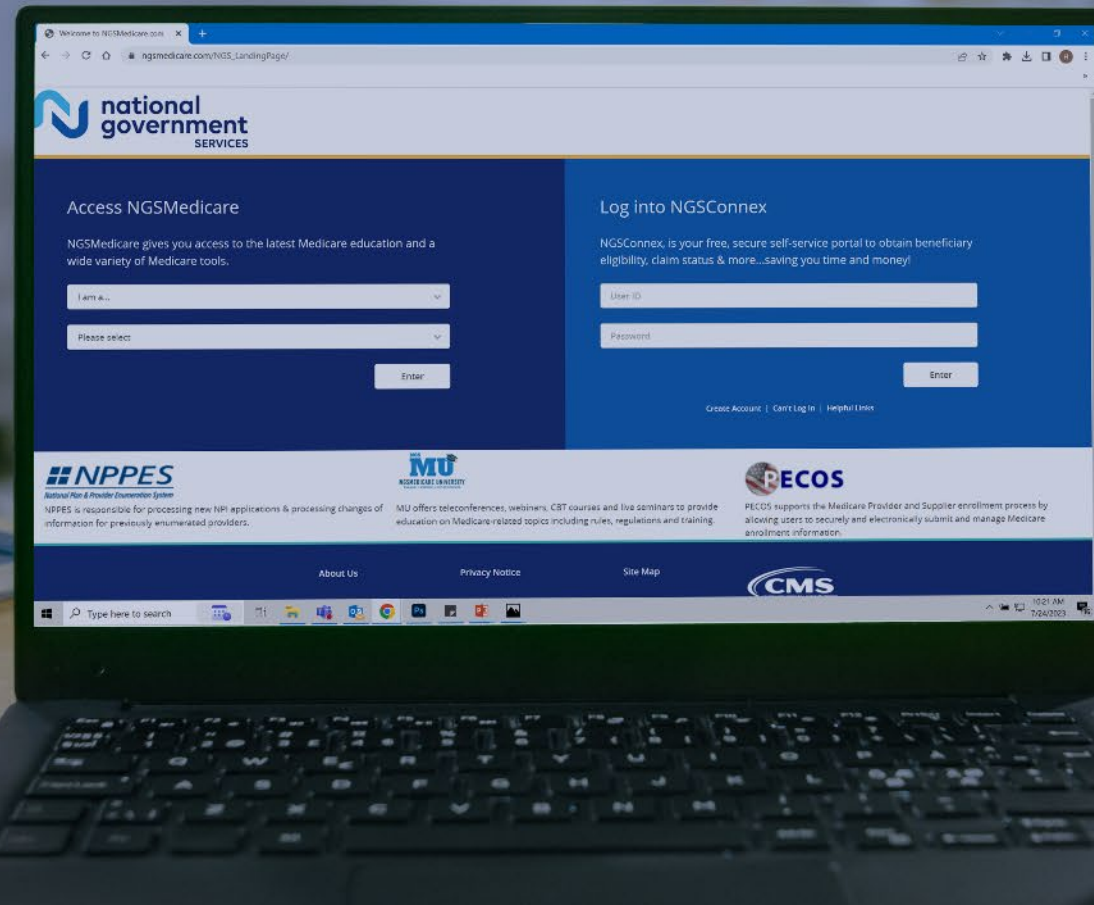


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