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Podiatry Services – Routine Foot Care and Debridement of Nails

11/13/2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenters

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Objective

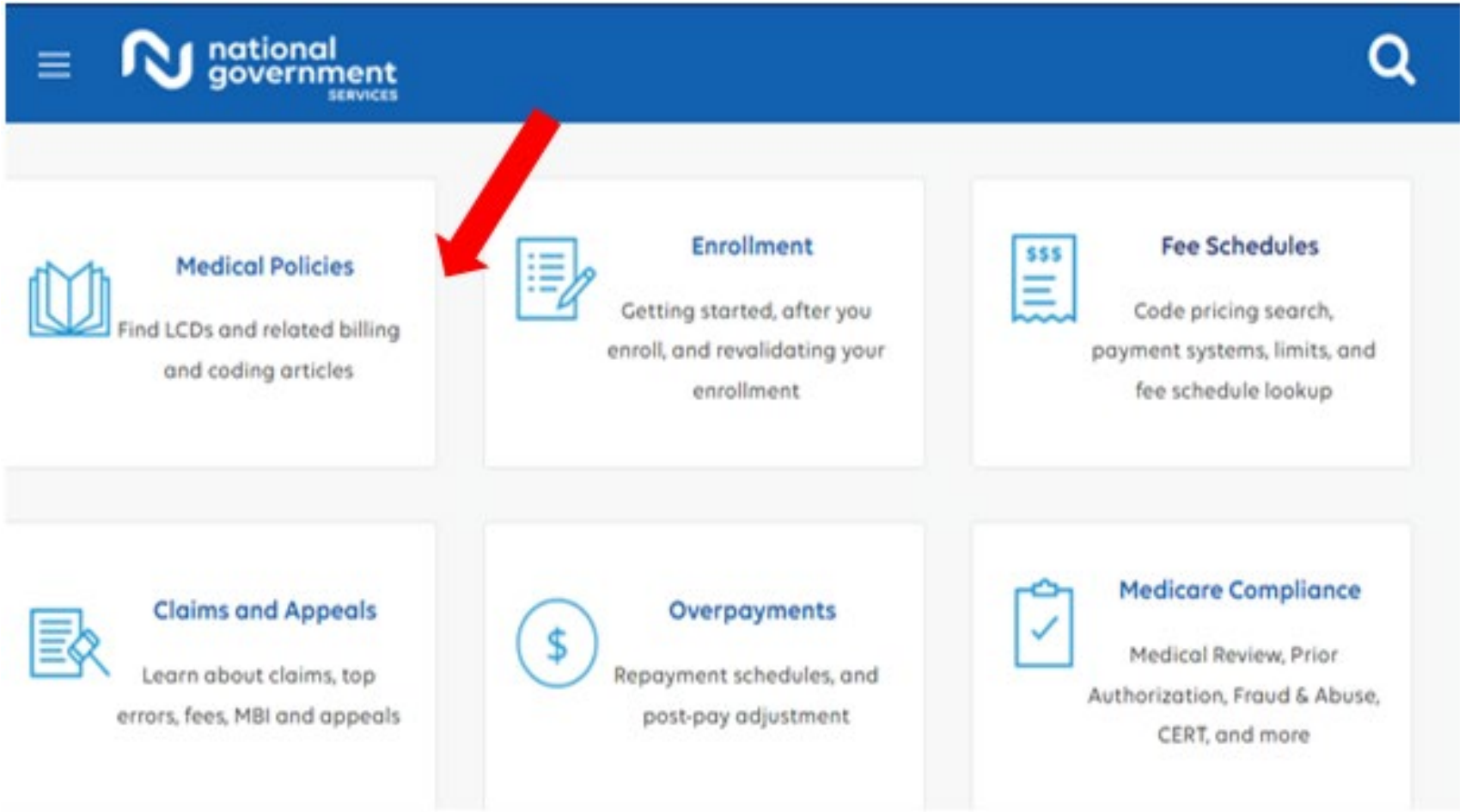
To assist providers and their billing staff to have a better understanding of the routine foot care and debridement of nails local coverage determination and the related coverage article.

Agenda

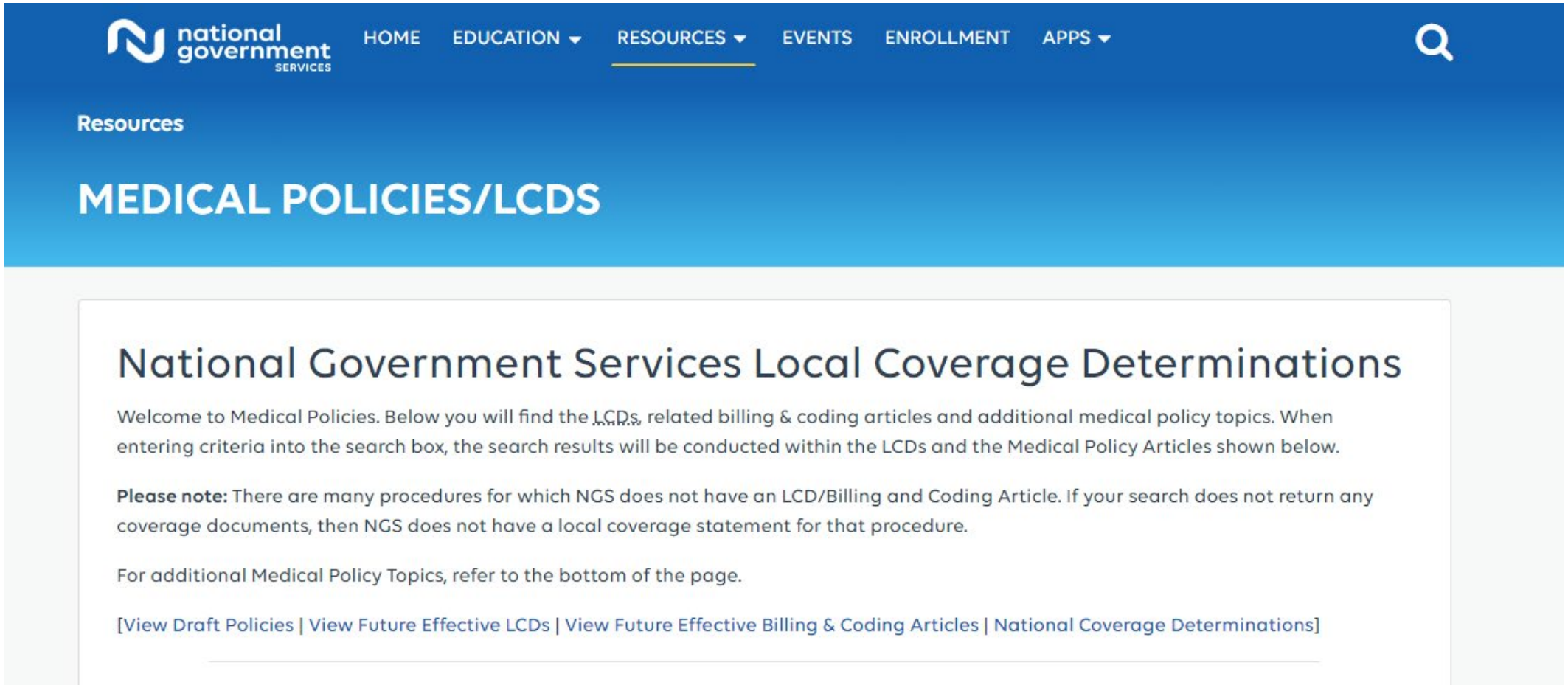
- Medical Policies/LCDs
- LCD for Routine Foot Care and Debridement of Nails (L33636) and Related Coverage Article (A57759)
- Billing Tips to Avoid Costly Appeals
- E/M and Modifier 25
- National Correct Coding Initiative
- Medical Review
- Test Your Knowledge
- Resources

Medical Policies/LCDs

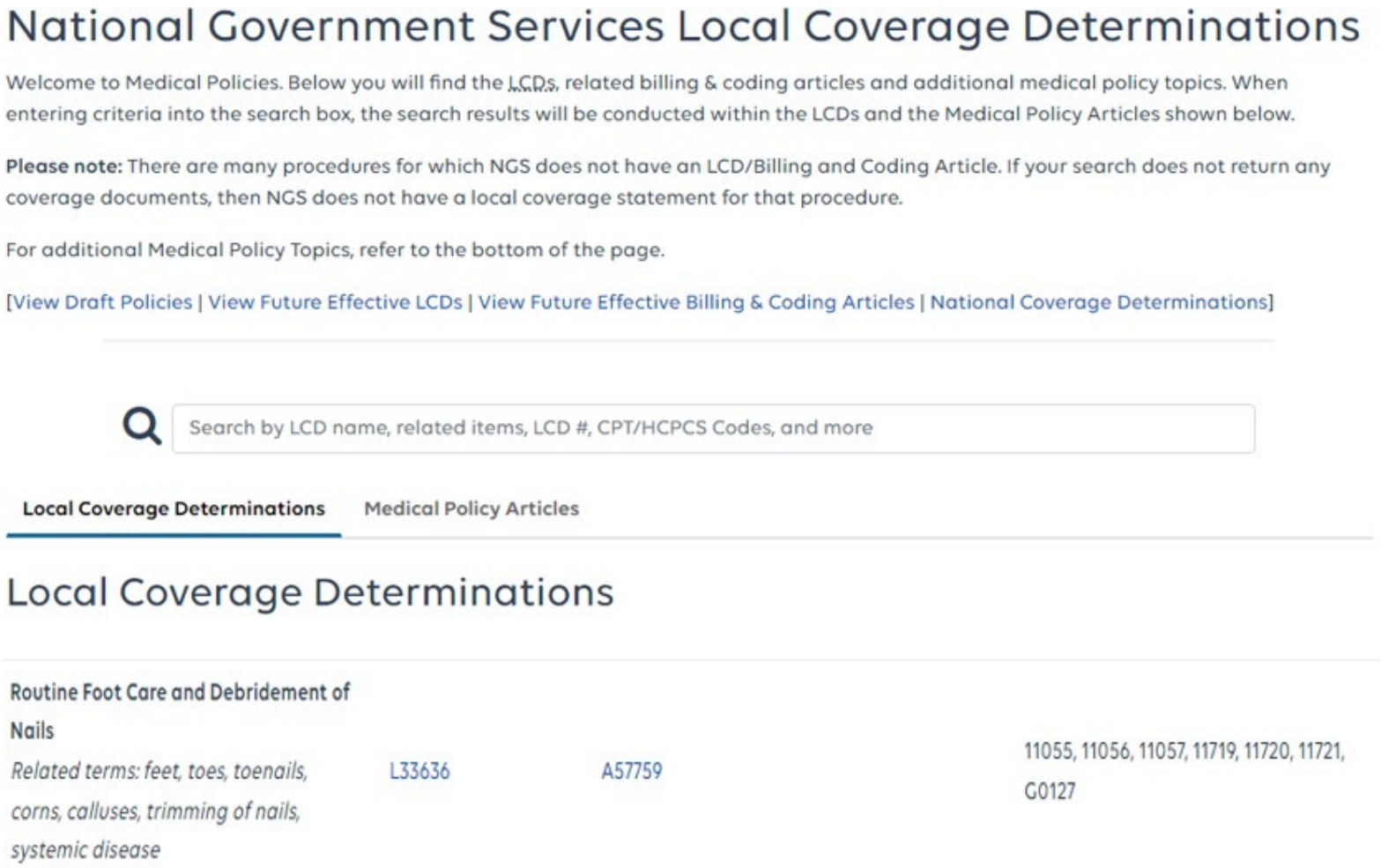
Medical Policies



Medical Policies - LCDs



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.

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]

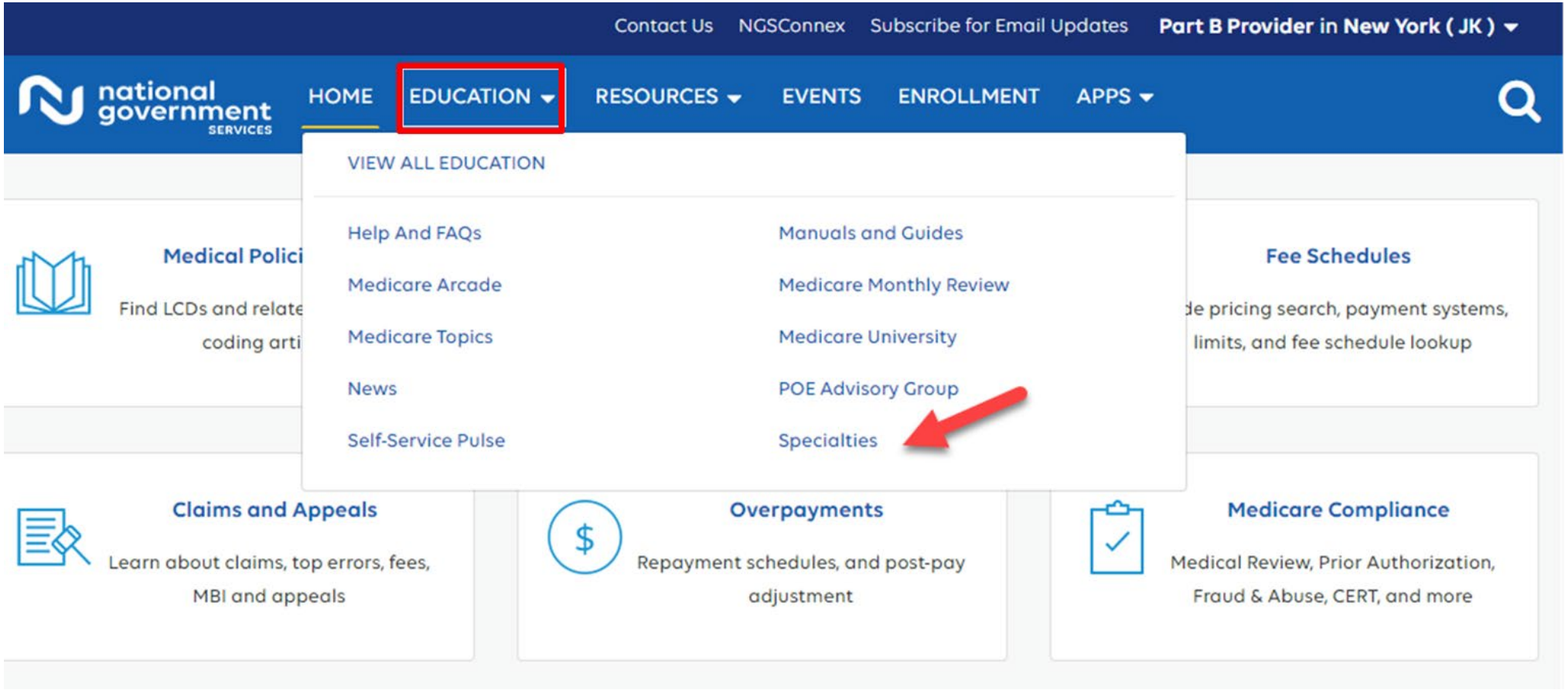
Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | Medical Policy Articles

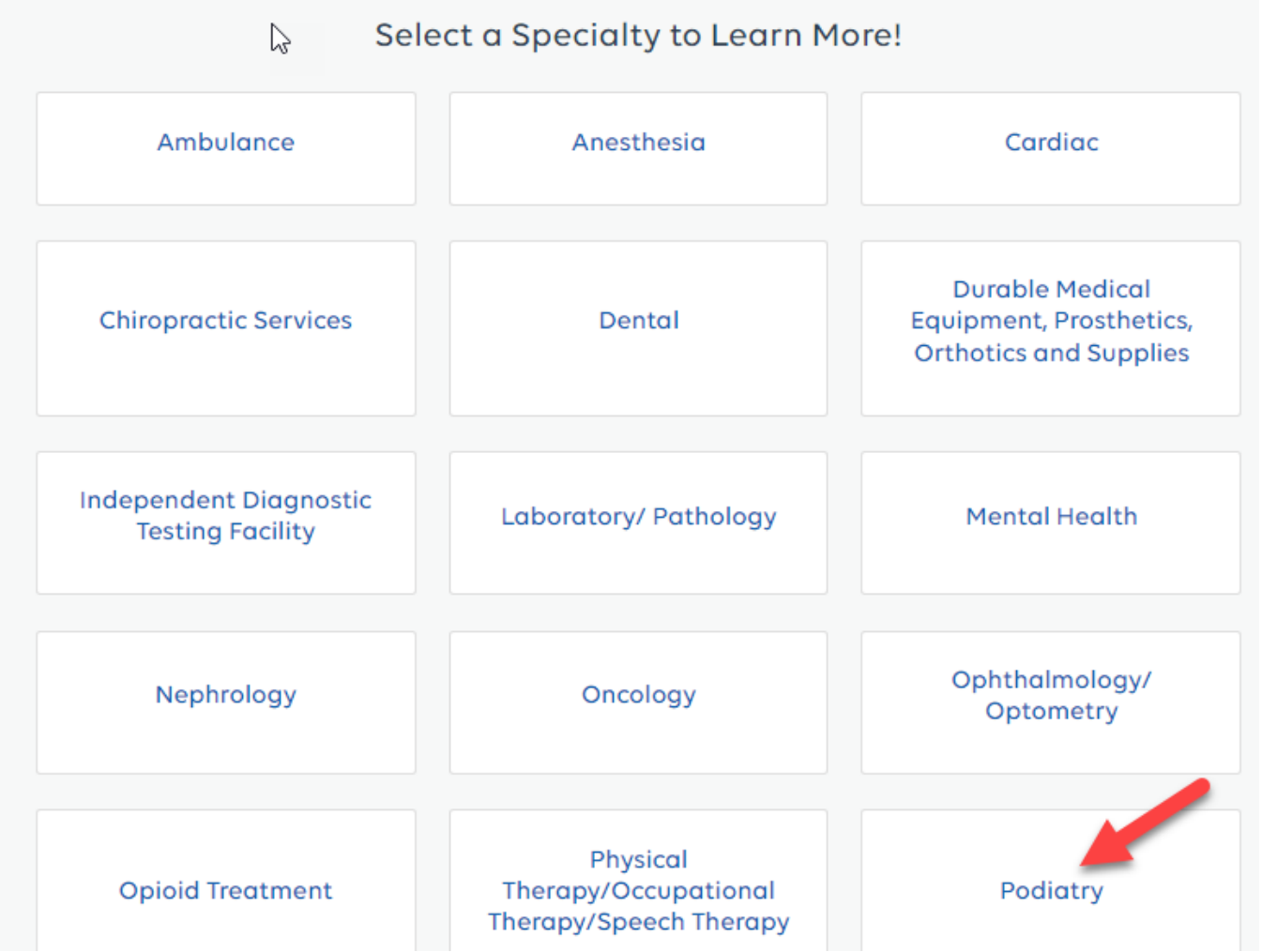
Local Coverage Determinations

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

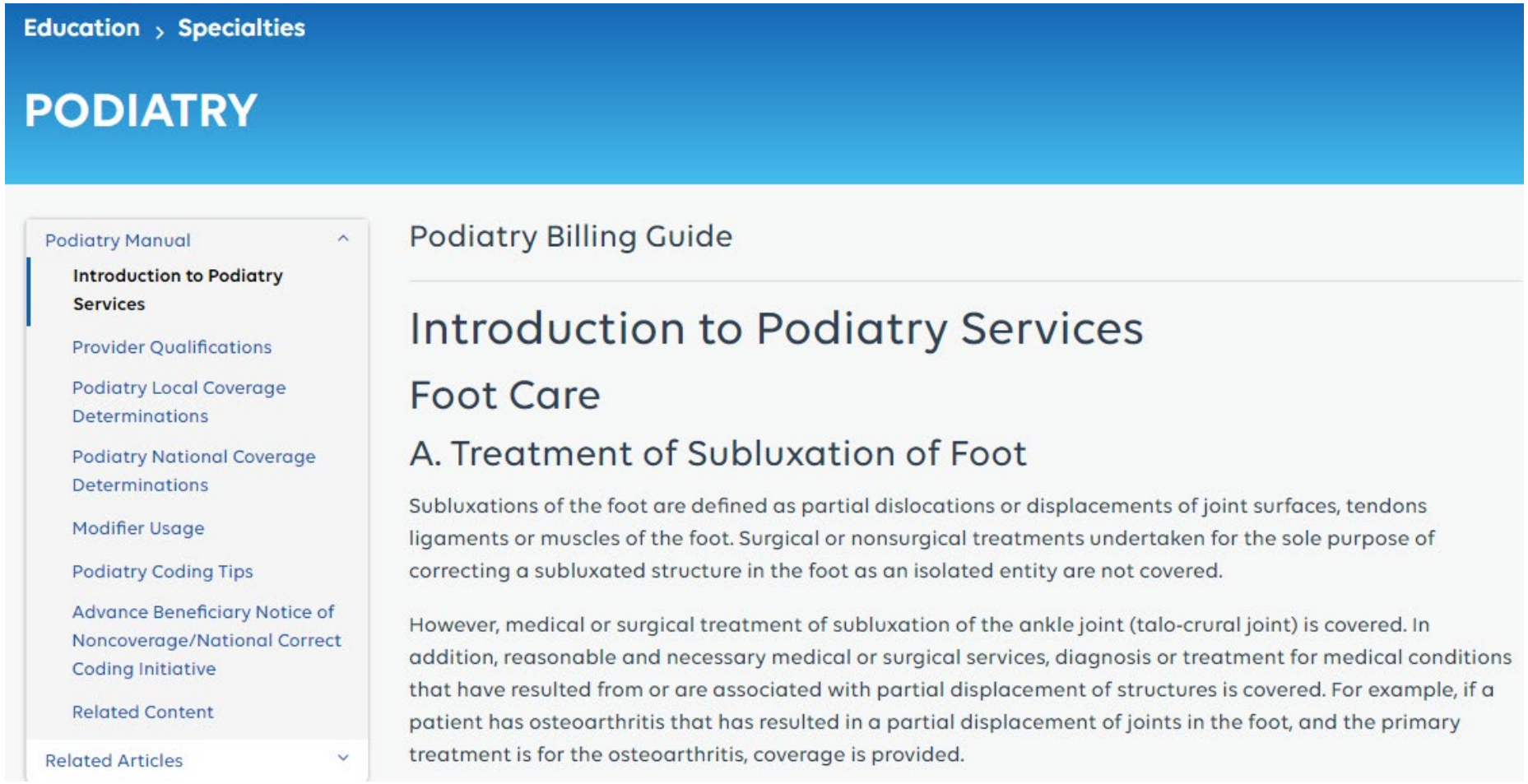
Podiatry Billing Guide Home Page



Podiatry Billing Guide
Select Specialty



Podiatry Billing Guide



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

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

Indications of Coverage

- Must be of sufficient severity that performance of such services by a nonprofessional person would put patient at risk
- Foot care services that do not require a professional would be considered routine and not a Medicare benefit
- Professional in this situation is defined as an M.D., D.O., D.P.M., nurse practitioner, clinical nurse specialist, or physician assistant
- Foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet

Indications of Coverage

- Services considered routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of
  - Ulcers
  - Wounds
  - Infections
- The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body

Billing CPT/HCPCS Codes

- 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

Indications of Coverage

- Specific indications or exceptions under which routine foot care are program benefits
  - Systemic disease
    - Metabolic
    - Neurologic
    - Peripheral vascular disease
- Documentation of the class findings supports these conditions

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 such as (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

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 findings
  - Refer to group four paragraph and codes for those diagnoses where the patient has evidence of neuropathy, but no vascular impairment, for which **class findings modifiers are not required**

Mycotic Nails

- Treatment of mycotic nails or onychogryphosis or onychauxis may be covered under the exceptions to the routine foot care exclusion when one of the situations is present
  - Systemic conditions with adequate documentation of class findings and the use of the appropriate modifier, indicating the presence of qualifying systemic illnesses causing a peripheral neuropathy
  - Payment may be made for the debridement of a mycotic nail (whether by manual method or electrical grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit and the physician attending the mycotic condition documents that the criteria are met
  - OR in the absence of a systemic condition, the following criteria on next slide must be met

Mycotic Nail – Absence of Systemic Condition

- 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

Routine Foot Care Services Performed by a Registered Nurse

- Effective for dates of service on or after 12/1/2023, a registered nurse that holds foot care certification (CFCN®) may perform covered foot care services when all the following requirements are met
  - Services are performed under direct supervision of a physician or other practitioner
  - All requirements of the “incident to” provision are met per the CMS Medicare Benefit Policy Manual
  - Proof of accredited foot care nurse certification must be included in the documentation
  - All other coverage provisions outlined in this Billing and Coding Article are met
- Providers should be aware that this may not be allowed, based on their state scope of practice laws

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's 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

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

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*

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

Documentation Requirements

- There must be adequate medical documentation to demonstrate the need for routine foot care services as outlined in this determination
- This documentation may be office records, physician notes or diagnoses characterizing the patient's physical status as being of such severity to meet the criteria for exceptions to the Medicare routine foot care exclusion
- The billed diagnoses should be reported with clinical findings
- There should be documentation of co-existing systemic illness
- The physical examination and findings must be precise and specific, with documentation of the location, appearance, characteristics and symptoms of the nails and/or lesion(s)
- The procedure note may reference the physical examination when describing the treatment(s) given during the procedure (e.g., left great toe, or right foot, 4th digit)

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.

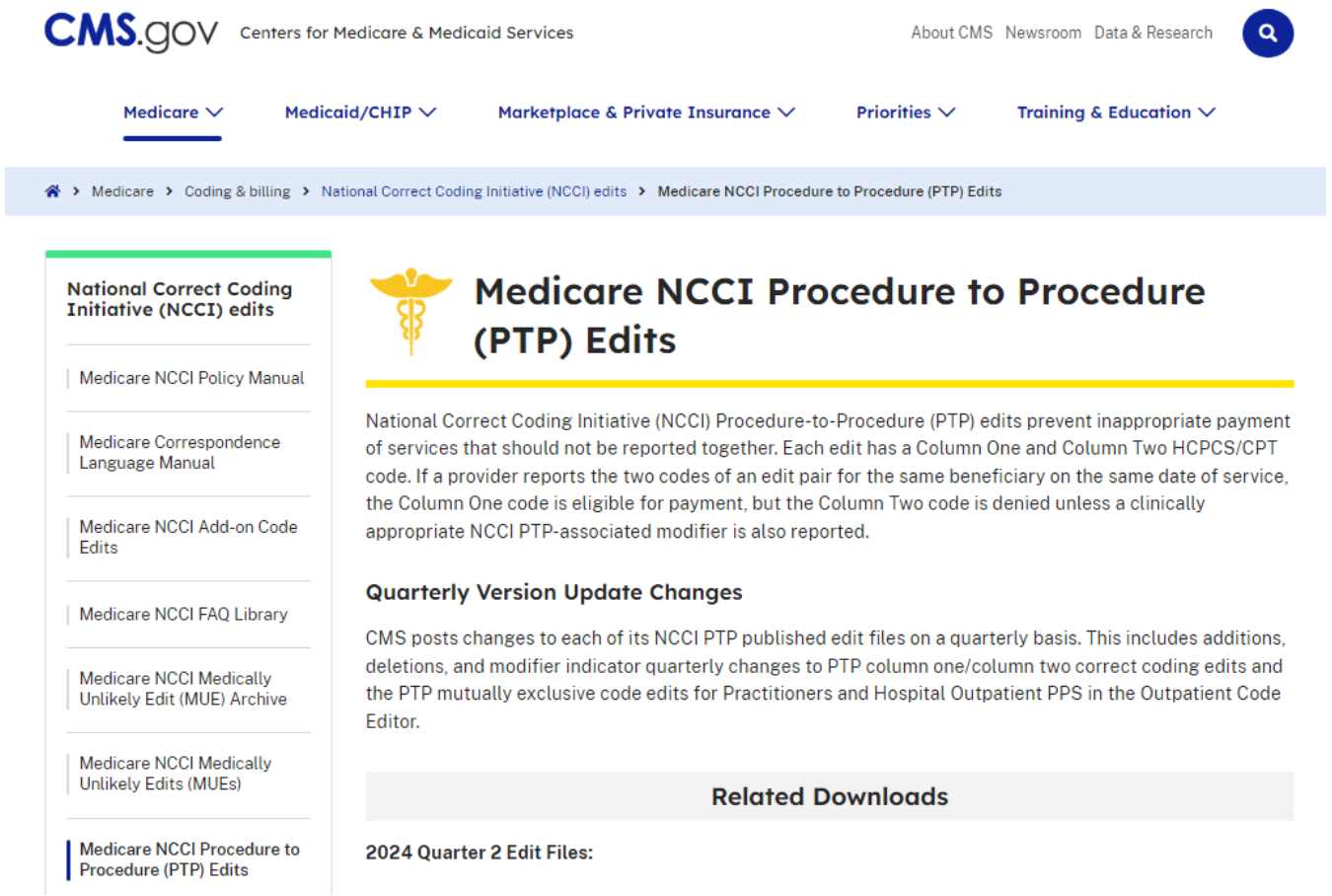
Inappropriate Use of Modifier 25

- 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.

National Correct Coding Initiative

Where to Find NCCI Edits

- PTP Coding Edits



National Correct Coding Initiative Example 1

Column 1	Column 2	Effective Date	Modifier 0=not allowed 1=allowed 9=not applicable
11720	99347	19990101	1

National Correct Coding Initiative Example 2

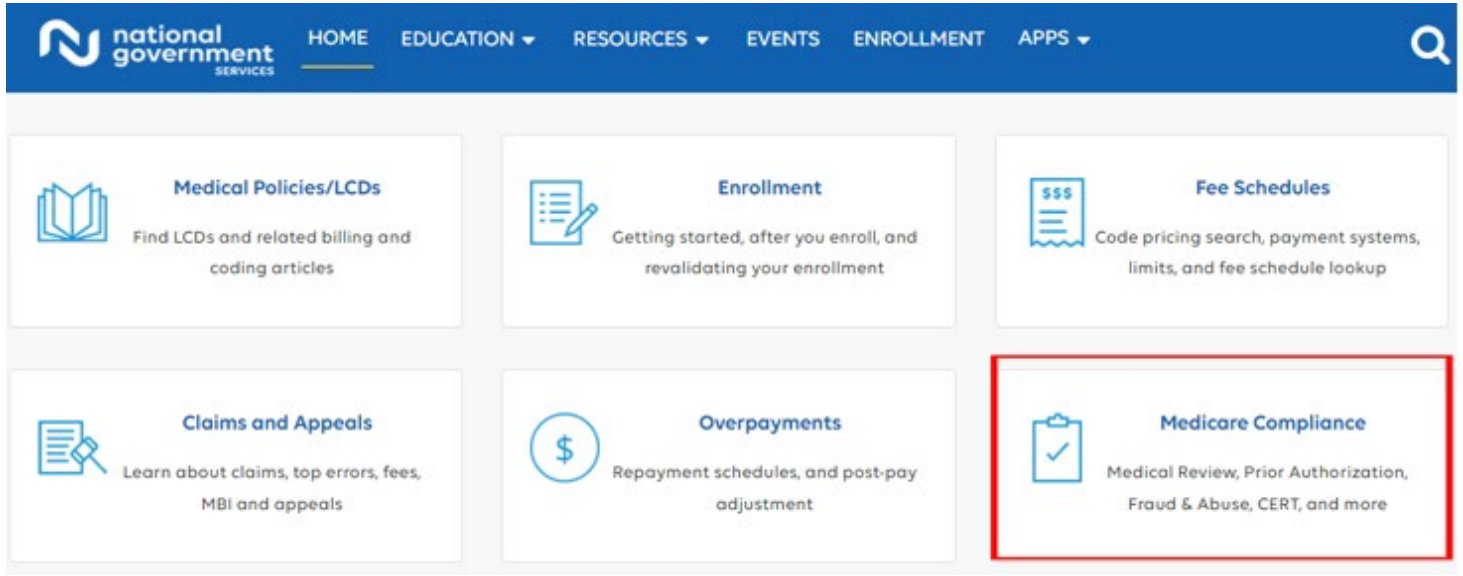
Column 1	Column 2	Effective Date	Modifier 0=not allowed 1=allowed 9=not applicable
11719	G0127	19980401	0

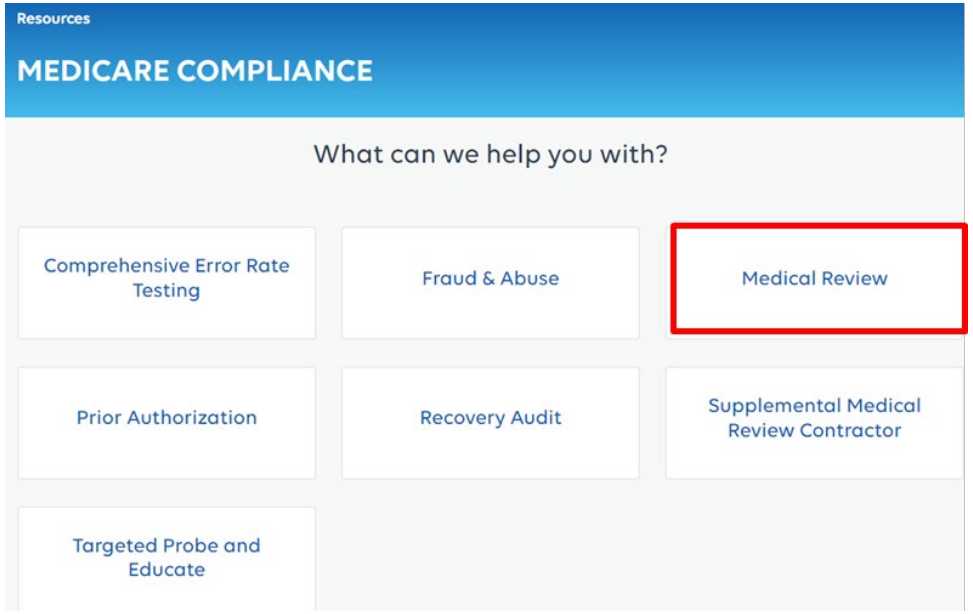
Modifier 59 and the Subset Modifiers XE, XP, XS, XU

- Modifier 59 is used to identify distinct 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
- Modifier XE – Separate Encounter
  - A service that Is distinct because it occurred during a separate encounter
- Modifier XP – Separate Practitioner
  - A service that is distinct because it was performed by a different practitioner
- Modifier XS – Separate Structure
  - A service that is distinct because it was performed on a separate organ/structure
- Modifier XU – Unusual Nonoverlapping Service
  - The use of a service that is distinct because it does not overlap usual components of the main service

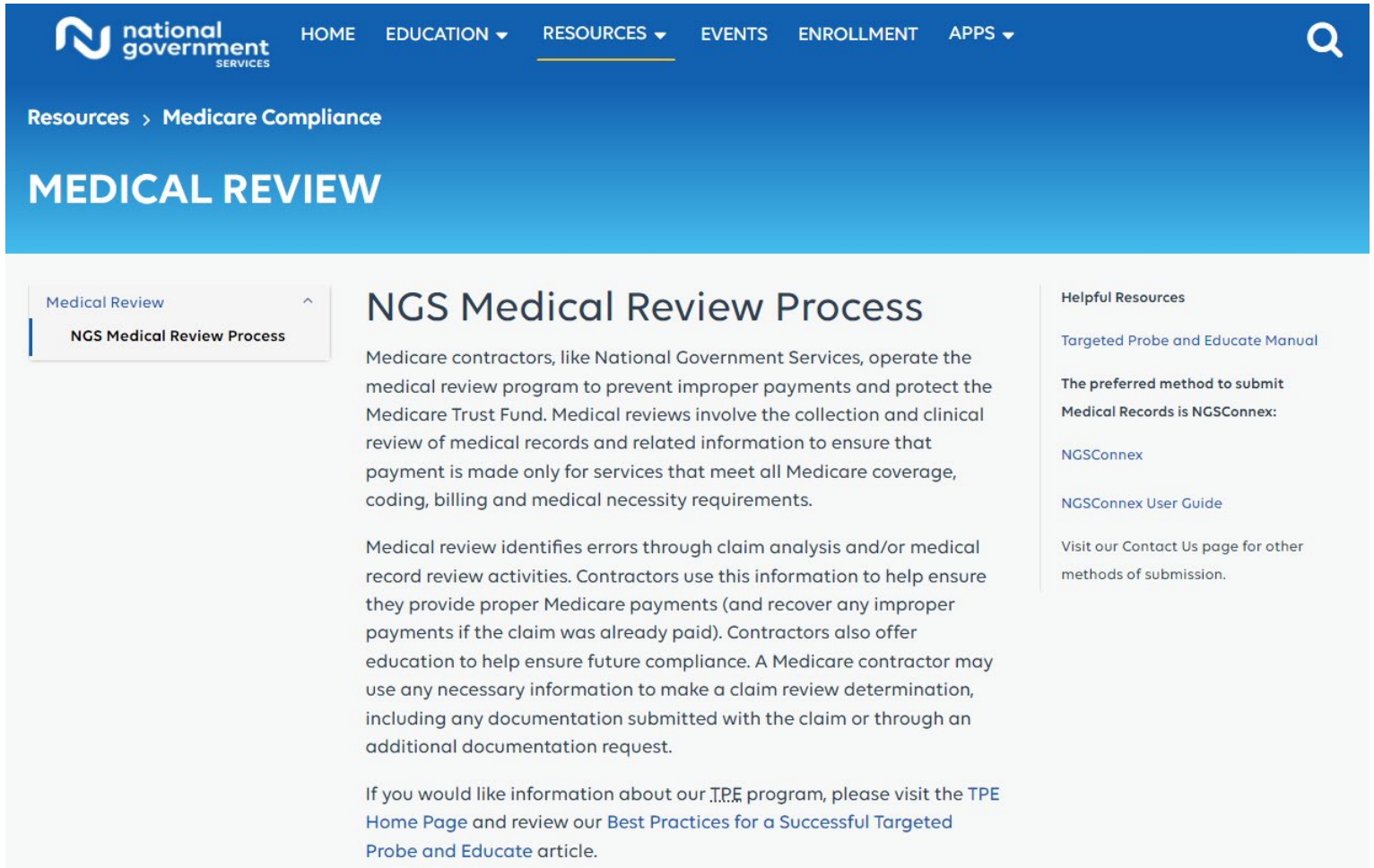
Medical Review

Medical Review





Medical Review Process



Medical Review Target Probe and Educate (TPE)

- Program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help
- TPE reviews may involve claims that have already been processed (postpayment)
  - Notification letter will include a listing of all the claims being selected
- New claim submissions (prepayment)
  - Includes a notification letter followed by separate ADRs for each claim

Jurisdiction K Part B Targeted Probe and Educate: Medical Review Topics

Paring or Cutting of Benign Hyperkeratotic Lesion	11055, 11056, 11057	A07 - The documentation does not support the medical necessity per policy guidelines. • The documentation does not include some or all of the required elements including the necessary class findings, the presence of a qualifying systemic illness causing a peripheral neuropathy, and/or does not include precise and specific findings including specific location of lesion(s). • The documentation does not support the class findings modifier billed. 362 - The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.	Local Coverage Determination (LCD): L33636- Routine Foot Care and Debridement of Nails CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 Title XVIII of the Social Security Act (SSA), Section 1833(e) Title XVIII of the SSA, Section 1862(a)(1)(A)
Trimming of Nondystrophic Nails and/or Nail Debridement with or without an E/M code	11719, 11720, 11721, 99211 99215	B65 - Services not furnished directly to the patient and/or not documented. • The documentation does not support that nondystrophic nails were present and/or treated. 362 - The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.	Local Coverage Determination (LCD): L33636- Routine Foot Care and Debridement of Nails CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 30 CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.6B Title XVIII of the SSA, Section 1833(e)

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

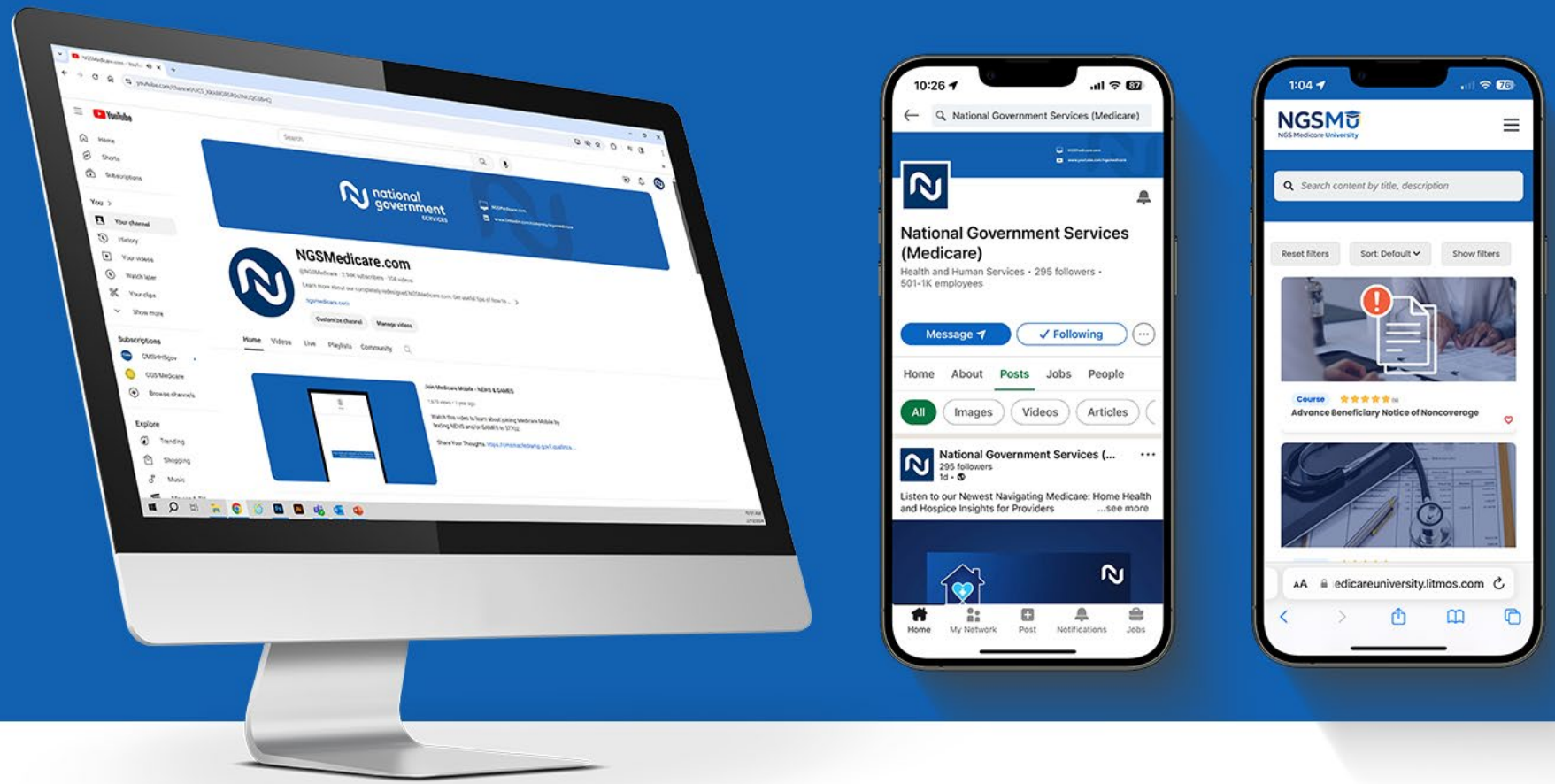
Resources

Resources

- Medical Policy Center
- 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

Questions?

Thank you!



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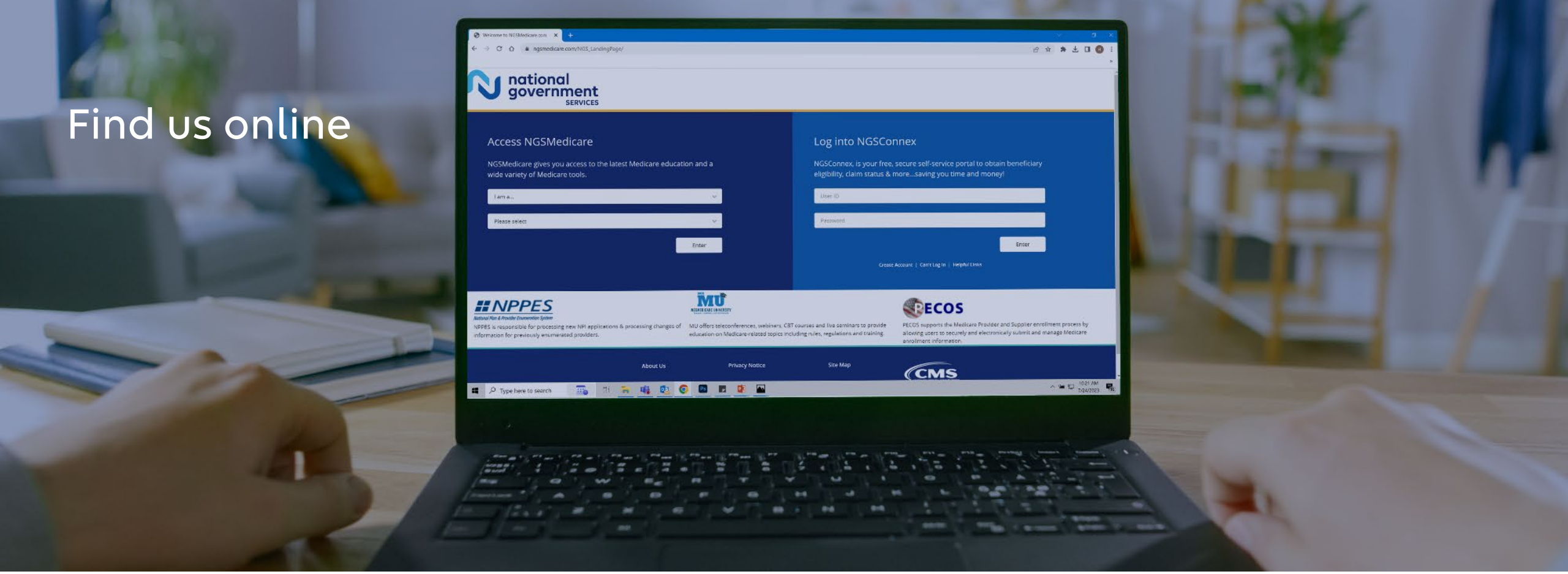

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