

# No More Guessing – CPT Coding for “Foot Care” the Right Way

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[ 1 ]

# DO YOU DO COMBINATION CODING?

FOOT CARE IS OFTEN IN  
COMBINATION, EVERYTHING IS NOT  
CPT 11721!

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( 2 )

# FOOT CARE NCCI EDITS

- CPT 11719
- CPT 11720-59/XS
- CPT 11055 (6, 7)
- CPT 11720-59/XS
- G0127
- CPT 9920x-25

~~CPT 11719~~

~~CPT 11721-59/XS~~

- CPT 11719
- CPT 9920x-25

CPT 11720

CPT 9920x-25

- CPT 11721
- CPT 9920x-25

CPT 11055 (6, 7)

CPT 11721-59/XS

- CPT 11719
- ~~G0127-59/XS~~

CPT 11720

G0127-59/XS

- CPT 11721
- ~~G0127-59/XS~~

Established E/M codes require a “-25” modifier when billed with any routine foot care code

# COMBO CODE OPTIONS

- CPT 11719-59/XS
- CPT 11720-59/XS
- CPT 11055
- CPT 9920x-25
- CPT 11719-59/XS
- CPT 11720-59/XS
- CPT 11056
- CPT 9920x-25

**CPT 11720-59/XS**  
**HCPCS G0127-59/XS**  
**CPT 11055**  
**CPT 9920x-25**

**CPT 11720-59/XS**  
**HCPCS G0127-59/XS**  
**CPT 11056**  
**CPT 9920x-25**

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# COMBO CODE OPTIONS

- **CPT 11719-59/XS**
- **CPT 11720-59/XS**
- **CPT 11057**
- **CPT 9920x-25**

**CPT 11720-59/XS**

**HCPCS G0127-59/XS**

**CPT 11057**

**CPT 9920x-25**

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# Why Pain or Marked Limitation of Ambulation Secondary to thickened nail(s) is not the best option?

- Does your patient come into the office complaining that their mycotic nails are so bad that there is pain with walking limiting their ambulation ?
- There nails are so painful that they need a cane, walker or wheelchair?

# Data shows that CPT 11721 is highly billed making it a target code for audits and OIG!

- It is this lecturer's opinion that "Foot Care" should be primarily billed most often for only covered services when the patient meets the At Risk Foot Care Guidelines!
- On rare occasions would you bill pain or limits on ambulation.

# RFC: Systemic Condition-Class Findings, what is the fuss?

1. Cutting corns/calluses; trimming/debriding nails
2. No symptoms (i.e., **pain is not a factor**)
3. Need a qualifying systemic condition based on your Medicare contractor's LCD and/or Medicare coverage language



# Key Criteria that can pass....

- Severe circulatory embarrassment (peripheral vascular disease)
- Areas of diminished sensations on legs and/or feet (neurologic – loss of protective sensation)
- Other metabolic conditions

# Key Criteria that can pass....

- Class findings – A, B, C – validate the presumption of coverage; in cases of nonvascular systemic conditions, the ICD-10 code validates the presumption of coverage
- MD/DO name, NPI, and date last seen are only required when using a systemic condition labeled with an asterisk (\*)

# But Wait is it only MD/DO?

## First Coast (FL)

- The name of the attending physician (M.D., D.O., or non-physician practitioner [PA or NP]) who is actively treating the patient's condition, and
- The date the patient was last seen by the M.D., D.O., or non-physician practitioner (PA or NP) who is actively treating the condition (this date must be within six months), or the patient had come under such care shortly after the services were furnished usually as a result of a referral.
- Also, for non-asterisked conditions, the name of the M.D., D.O., or non-physician practitioner (PA or NP) who diagnosed the complicating condition must be on the claim form.

(Information from Billing and Coding: Routine Foot Care (A57188) Original Effective Date 10/03/2018 )

# But Wait is it only MD/DO?

## Novitas

When the patient's condition is designated by an ICD-10-CM code with an asterisk (\*) (see ICD-10-CM Codes in the Local Coverage Article: Billing and Coding: Routine Foot Care [A52996]), routine foot care procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) or NPP for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service or if the patient had come under a physician's or NPPS care shortly after the services were furnished.

(information from Revision Effective Date For services performed on or after 10/17/2019)

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12

# But Wait is it only MD/DO?

## Palmetto GBA

- An asterisk (\*) above, routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy or NPP who documents the condition.
- The date the patient was last seen by the attending physician should be billed in block 19. Claims for such routine services should show the complicating systemic disease

(information from Billing and Coding: Routine Foot Care (A56680) Revision Effective Date 12/05/2019)

# But Wait is it only MD/DO?

## NGS

- \* For these diagnoses, the patient must be under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service.

(information from Billing and Coding: Routine Foot Care and Debridement of Nails (A57759) Original Effective Date 12/26/2019)

# But Wait is it only MD/DO?

## NORIDIAN

- NO Foot Care LCD, means defaults to the CMS Policy on Routine Foot Care.

# But Wait is it only MD/DO?

## WPS

- For diagnosis codes designated by an asterisk (\*), it is required the patient be under the active care of Doctor of Osteopathy (D.O.) or Doctor of Medicine (M.D.) The active care requirement would be considered met if the claim indicates that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the 6-month period prior to the service.
- Professional in this situation is defined as an M.D., D.O., D.P.M., Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant.

(NO Foot Care LCD, but a LCA-Billing and Coding: Foot Care (A56232).  
Revision Effective Date 11/01/2019)



# But Wait is it only MD/DO?

## CGS

- ICD-10-CM code that indicates the routine foot care was done based on the patient having a complicating disease, the procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy (MD or DO) or qualified non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six (6) month period prior to the rendition of the routine-type service or if the patient had come under a physician's care shortly after the services were furnished.

(Routine Foot Care and Debridement of Nails (L34246) Revision Effective Date  
For services performed on or after 11/28/2019)

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# Terminology Varies

1. “Nail debridement involves the removal of excessive nail material (i.e., the reduction of nail thickness or bulk) from clinically thickened, diseased (e.g., mycotic or dystrophic) nail plate that may or may not also be misshapen in appearance or brittle in characteristic. Upon completion, nail debridement should result in a reduction of the nail to approximate as reasonable as possible normal nail thickness.”
2. “Nail trimming involves the reduction in the length of a nail.”

# Terminology Varies

- “Confirmation of mycotic nail infections by laboratory tests such as fungal cultures and/or stains is not necessary for Medicare coverage of debridement when clinical findings are strongly supportive of the diagnosis and treatment is not contraindicated.”

# Terminology Varies

- Evaluation and management (E/M) services for any of the conditions defined as routine foot care will be considered ineligible for reimbursement, with the exception of the initial E/M service performed to diagnose the patient's condition.
- Evaluation and management (E/M) services provided on the same day as routine foot care by the same doctor for the same condition are not eligible for payment except if it is the initial E/M service performed to diagnose the patient's condition or if the E/M service is a significant separately identifiable service indicated by the use of modifier 25, and documented by medical records.

**Example 4:** Column 1 Code / Column 2 Code - 11055/11720

>CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion

>CPT Code 11720 – Debridement of nail(s) by any method(s); 1 to 5

CPT codes 11720 and 11055 should not be reported together for services performed on *skin distal to and including the skin overlying the distal interphalangeal joint of* the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion *of the skin on or distal to the distal interphalangeal joint* is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail *or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.*

**Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

Reference - <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>

# Questions?

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