Podiatry

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Routine Foot Care

Cutting or removing corns and calluses

Clipping, trimming, or debridement of nails

Non-definitive simple, palliative treatments like shaving or paring plantar warts which do not require thermal or chemical cautery and curettage

Other hygienic and preventive maintenance care in the realm of self care (i.e. cleaning, soaking, use of creams to maintain tone) for both ambulatory and bedridden patients

Any services performed in the absence of localized illness, injury, or symptoms involving the feet.

Routine Foot Care

Medicare will cover routine foot care services if:

- Systemic disease such as metabolic, neurologic, or peripheral vascular disease is of sufficient severity that non-professional performance of such services would put the patient at risk
- Treatment of warts covered the same extent as any other body area
- Covered if integral to other covered services such as ulcer, wound or infection control
- Patients with mycotic nails with sufficient class findings, or the presence of a qualifying systemic illness causing a peripheral neuropathy
  - Mycotic nails without systemic illness may also be covered as defined in mycotic nail policy

Understanding The Policy

MEDICARE CALLS TRIMMING, DEBRIDEMENT OF CORNS & CALLOUSES AND DEBRIDEMENT OF NAILS "ROUTINE FOOT CARE" EVEN IF A PATIENT HAS SYSTEMIC DISEASE.

THERE ARE TIMES WHEN "ROUTINE FOOT CARE" IS COVERED BY MEDICARE AND TIMES WHEN IT IS NOT COVERED.

MEDICARE EXPECTS PROVIDERS TO KNOW MEDICARE COVERAGE POLICY AND IDENTIFY COVERED FOOT CARE SERVICES WITH APPROPRIATE COVERAGE MODIFIERS

CONVERSELY, MEDICARE EXPECTS PROVIDERS TO IDENTIFY NON-COVERED SERVICES AND APPEND CLAIMS NON-COVERAGE MODIFIERS.

Novitas Policy

- It is not appropriate to bill Medicare for services that are not covered (as described by LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.
  - GZ: Item is expected to deny due to medical necessity (should be denied as provider liability)
  - GA: ABN (waiver signed, patient liability). Used in private sector settings.
  - GY: Not covered by statute (Do not use for debridement or any other service which has a medical policy and is covered for some dx and not others)

Novitas Policy

Novitas has multiple local coverage determinations that must be referenced when coding podiatry.

LCD L35013 – Debridement of mycotic Nails

- Only covers nail debridement diseased nails
  - Patient must have qualifying dx (diseased nails and systemic illness) and
  - Patient must have sufficient class findings (Q7, Q8, or Q9)
- OR
- Diseased nails with pain in limb or difficulty in walking due to mycotic nails OR
- Has secondary soft tissue inflammation or infection resulting from thickening and dystrophy of the infected nail plate

Lcd l35138 – Routine foot care

- Covers treatment of corns, callus, and debridement of nails
- Patient must have qualifying diagnosis (systemic illness) and
- Patient must have sufficient class findings (Q7, Q8 or Q9)

LCD L34887 – SURGICAL TREATMENT OF NAILS

LCD L35125 – WOUND CARE

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00092534

Pairing or cutting benign hyperkeratotic lesions

* ROUTINE FOOT CARE

CPT Code	Description
11055*	Pairing or cutting of benign hyperkeratotic lesion (e.g. corns or callus); single lesion
11056*	Pairing or cutting of benign hyperkeratotic lesion (e.g. corns or callus); 2 to 4 lesions
11057*	Pairing or cutting of benign hyperkeratotic lesion (e.g. corns or callus); more than 4 lesions

- It is not appropriate to report procedure codes 11305-11308 (Shaving of epidermal or dermal lesion) for the pairing or cutting of corns and callus.
- For all claims for foot-care services, report a foot/toe location modifier (when appropriate)

Trimming & Debridement

* Routine Foot care

CPT	Trimming Description
11719*	Trimming of nondystrophic nails, any number
G0127*	Trimming of dystrophic nails, any number

CPT	Debridement Description
11720*	Debridement of nail(s) by any method; 1 to 5
11721*	Debridement of nail(s) by any method: 6 or more

Nail trimmings may be miscoded as nail debridements. Trimmings include cutting or trimming the nail in order to decrease the length of the nail. Nail debridements are more involved than trimming. The length of the nail may be reduced like a trimming, but the provider is also reducing the girth or the thickness of the nail. Health Care Fraud Shield December 4, 2014

Foot and Toe Modifiers

	Description
LT	Left foot
TA	First toe, left foot
T1	Second toe, left foot
T2	Third toe, left foot
T3	Fourth toe, left foot
T4	Fifth toe, left foot

	Description
RT	Right foot
T5	First toe, right foot
T6	Second toe, right foot
T7	Third toe, right foot
T8	Fourth toe, right foot
T9	Fifth toe, right foot

To be covered under the routine foot care exception:

Must have diagnosis listed in LCD I35138

- This diagnosis needs to be documented
- This diagnosis must be on the claim form

Must have certain condition(s)/symptoms called "Class Findings"

- Must be documented by physician
- Templates may be designed to support gathering this information to help ensure legitimate revenue is captured
- Conditions/signs if documented must be translated into Q coverage modifiers and must make the claim!

Additional Claim Requirement

When reporting one of the ICD-10-CM codes that fall under the "active care requirement" (code identified by asterisk), the date the beneficiary was last seen by the M.D./D.O., or qualified non physician practitioner, responsible for treating the underlying condition must be reported in line 19 of the CMS 1500 claim form or the electronic equivalent.

Class Findings

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144511

- Class A
  - Non-Traumatic amputation of foot or skeletal portion thereof.
    - **Ensure applicable services always gets coded with Q7 so it is covered**
- Class B
  - Absent Posterior Tibial Pulse
  - Absent Dorsalis Pedis Pulse
  - 3 of the following
    - Decreased or absence of hair growth
    - Nail changes (thickening)
    - Pigmentary changes (discoloration)
    - Abnormal skin Texture (thin, shiny)
    - Abnormal Skin Color (rubor or redness)
- Class C
  - Claudication
  - Temperature Changes (cold feet)
  - Edema
  - Paresthesias (abnormal spontaneous sensations in the feet)
  - Burning

Q7: One Class A finding

Q8: Two Class B findings

Q9: One class B and two class C findings

CMS Class Findings Routine Foot Care Coding Tool

Class A Finding:

1. Non Traumatic Amputation of foot or integral skeletal portion thereof

Class B Findings:

1. Absent Posterior Tibial Pulse
2. Absent Dorsalis Pedis Pulse
3. Individual description of three of any of the following:
   - *Decreased or absence of hair growth
   - *Nail changes (thickening)
   - *Pigmentary changes (discoloration)
   - *Skin Texture (thin, shiny)
   - *Skin Color (rubor or redness)

Class C Findings:

1. Claudication
2. Temperature Changes (e.g. cold feet)
3. Edema
4. Paresthesias (abnormal spontaneous foot sensations e.g. numbness, prickling or tingling).
5. Burning

Score the class findings then apply modifier if applicable:

- ☐ Q7: The class A finding
- ☐ Q8: Two class B findings
- ☐ Q9: One class B and two class C finding

This document is designed as a coding tool to be used with CMS coverage policy which states patient must have certain medical condition(s) in addition to the class findings. This tool is effective and current with Novitas Policy at the time of design: Novitas L27486 for services performed 12/04/2014.

McManis & Monsalve Associates

McManis and Monsalve Associates
January 2015

- Coding Tool is designed to be used with Novitas current policy for routine foot care.
- Patient must have both class findings and qualifying disease for applicable services to be covered.
- Note: To obtain the 3rd class B finding three of the 5 conditions must be documented.
- Templates may be designed to ensure physician may easily capture the class findings.
- Coders may append modifiers as applicable for

Documentation Requirements

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name dates of service(s)). The record must include the legible signature of the physician or non-physician practitioner responsible for and providing the care of the patient.

3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

4. The medical record documentation must support the medical necessity of the services as directed in this policy

5. Routine foot care services performed more often than every 60 days will be denied unless documentation is submitted with the claim to substantiate the increased frequency. This evidence should include office records or physician notes and diagnoses characterizing the patient's physical status as being of such an acute or severe nature that more frequent services are appropriate.

#5- claims may be automatically denied if more frequent than 60 days as part of a normal appeals process. Billing/coding needs to appeal with records

Documentation Requirements

6. For foot-care services covered by virtue of the presence of a qualifying, covered systemic disease (asterisked and non-asterisked elsewhere in this LCD), Medicare expects the clinical record to contain a sufficiently detailed clinical description of the feet to provide convincing evidence that non-professional performance of the service is hazardous to the patient. For this purpose, documentation limited to a simple listing of class findings is insufficient. Medicare does not require the detailed clinical description to be repeated at each instance of routine foot care when an earlier record continues to accurately describe the patient's condition at the time of the foot care. In such cases, the record should reference the location (i.e. date of service) in the record of the previously recorded detailed information. Further, detailed information so referenced should be made available to Medicare upon request.

   The patient's record must include the following:
   - Location of each lesion treated.
   - Identification (by number or name) and description of all nails treated.

Documentation Requirements

7. To distinguish debridement from trimming or clipping, Medicare expects records to contain some description of the debridement procedure beyond simple statements such as "nail(s) debrided."

8. For routine foot care and debridement of multiple symptomatic nails to people who have a qualifying systemic condition, the record should demonstrate the necessity of each service considering the patient's usual activities.

Documentation Requirements

9. Documentation of foot-care services to residents of nursing homes not performed solely at the request of the patient or patient's family/conservator must include a current nursing facility order for routine foot-care service issued by the patient's supervising physician that describes the specific service necessary. Such orders must meet the following requirements:

    - The order must be dated and must have been issued by the supervising physician prior to foot-care services being rendered.
    - Telephone or verbal orders not written personally by the supervising physician must be authenticated by the dated physician's signature within a reasonable period of time following the issuance of the order.
    - The order must be for medically necessary services to address a specific patient complaint or physical finding.
    - Routinely issued or "standing" facility orders for routine foot-care services and orders for non-specific foot-care services that do not meet the above requirements are insufficient.
    - Documentation of foot-care services to residents of nursing homes performed solely at the request of the patient or patient's family/conservator should indicate if the request was from the patient or the patient's family/conservator. When the request is from someone other than the patient the documentation should identify the requesting person's relationship to the patient.

Documentation Requirements

10. There must be adequate 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.

Novitas Mycotic Nail Debridement Novitas LCD L35013

- Patient must have qualifying diagnosis (diseased nails and systemic illness) and,
- Patient must have sufficient class findings (Q7, Q8, or Q9)

OR

- Diseased nails with pain in limb or difficulty in walking due to mycotic nails OR
- Has secondary soft tissue inflammation or infection resulting from thickening and dystrophy of the infected nail plate

Mycotic Nail Policy L35013

Covered when, whether or not services and patient conditions meet national requirements for routine foot care, there is clinical evidence of mycosis of the toenail, and the patient has marked limitation of ambulation due solely to pain due to the nails, (patients who are non-ambulatory for other reasons must have severe pain) or has secondary soft tissue infection resulting from the thickening and dystrophy of the infected nail plate.

Covered no more than once every 60 days.

Covered no more than six 11720 and/or 11721 sessions per patient per 12 months absent medical review of patient records demonstration medical necessity for the procedure. Claims will likely automatically deny- provider needs to appeal for medical necessity.

Mycotic Nail Policy L35013

- The treatment of symptomatic mycotic nails in the absence of a qualifying covered systemic condition will not be covered after the acute symptoms caused by mycosis have abated. In the absence of a qualifying systemic condition, debridement of six or more nails in a single encounter is not payable without medical review of records associated with the service.

Mycotic Nail Policy L35013

- Definitive treatment of mycotic nails involves the appropriate use of effective antifungal pharmacologic agents with or without periodic debridement. Medicare will cover debridement of mycotic nails as an adjunct to pharmacologic treatment with a prescription antifungal agent indicated per FDA label for treatment of fungal nail infections.

Mycotic Nail Policy L35013

- Mycologic confirmation by culture necessary to differentiate fungal disease from other nail pathology is required for Medicare payment of mycotic nail debridement in some circumstances such as previous unsatisfactory treatment results (recurrent nail disease, unsuccessful treatment with antifungal medications, long term (beyond 12 debridements per 24 months, etc.) and for patients whose debridement is prescribed absent of concomitant pharmacologic therapy, such as for patients deemed to be too high risk for oral antifungal medication use

Documentation Mycotic Nail Policy

- For mycotic nail debridement covered under the routine foot care exception. Medicare expects the clinical record to contain a sufficiently detailed clinical description of the feet to provide convincing evidence that non-professional performance of the service is hazardous to the patient.
- For this purpose, documentation limited to a simple listing of class findings is insufficient.
- Medicare does not require the detailed clinical description to be repeated at each instance of mycotic nail debridement when an earlier record continues to accurately describe the patient's condition at the time of the foot care. In such cases, the record should reference the location in the record of the previously recorded detailed information. Further, detailed information so referenced should be made available to Medicare upon request.

Procedure Documentation

In general, documentation of procedures should include but is not limited to:

- Diagnosis and applicable signs/symptoms
- Consent
- Aseptic preparation
- Description of the affected area(s) i.e. nails lesion(s)
- Description of the procedure: i.e. level of debridement and instruments used
- Patient tolerance
- Estimated blood loss or notation of bleeding (i.e. minimal or none)
- Follow up instructions

WOUND CARE

When the podiatrist or other clinician provides wound care, the following descriptors must be documented.

- Location
- Size
- Odor
- Depth
- Signs of infection (if any)
- Type of wound (DM ulcer, Post-op wound, other wound)

CMS - Wound care

Medicare coverage for wound care on a continuing basis for a given wound in a given patient is contingent upon evidence documented in the patient's medical record that the wound is improving in response to the wound care being provided. Evidence of improvement may include measurable changes in the following:

- Drainage
- Inflammation
- Swelling
- Pain and/or tenderness
- Wound dimensions (surface measurements, depth)
- Granulation tissue
- Necrotic tissue/slough
- Tunneling or undermining

Wound care during the global period

Medicare includes the following services in the global surgery payment when provided in addition to the surgery:

- Pre-operative visits after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery
  - Post-surgical pain management by the surgeon
  - Supplies, except for those identified as exclusions
  - Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

Post-Operative Period Billing

- 99024
  - Routine follow-up visits during the global period are coded with 99024. There is no separate reimbursement for an evaluation and management service related to the surgical procedure during the global period.

THANK YOU!

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