Podiatry Webinar

Presented by:
Medicare Part B Provider Outreach and Education (POE)
August 2016
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<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>ABN</td>
<td>Advance Beneficiary Notice of Non Coverage</td>
</tr>
<tr>
<td>CCI</td>
<td>Correct Coding Initiative</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
</tr>
<tr>
<td>EDISS</td>
<td>Electronic Data Interchange Support Services</td>
</tr>
<tr>
<td>DPM</td>
<td>Doctor of Podiatric Medicine</td>
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<tr>
<td>E/M</td>
<td>Evaluation and Management</td>
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<tr>
<td>IOM</td>
<td>Internet Only Manual</td>
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<td>LCD</td>
<td>Local Coverage Determination</td>
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<tr>
<td>ACRONYM</td>
<td>DESCRIPTION</td>
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<tr>
<td>---------</td>
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<tr>
<td>MD</td>
<td>Doctor of Medicine</td>
</tr>
<tr>
<td>MLN</td>
<td>Medicare Learning Network</td>
</tr>
<tr>
<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
</tr>
<tr>
<td>MSP</td>
<td>Medicare Secondary Payer</td>
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<tr>
<td>NPP</td>
<td>Non Physician Practitioner</td>
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<td>NCCI</td>
<td>National Correct Coding Initiative (Practitioner PTP Edits)</td>
</tr>
<tr>
<td>NCD</td>
<td>National Coverage Determinations</td>
</tr>
</tbody>
</table>
Agenda

• General Podiatry Coverage
• Excluded Services
• Routine Foot Care
• Evaluation & Management Services
• Debridement of Nails
Agenda

- Mycotic Nails
- Billing Requirements
- NCDs and LCDs
- NCCI
- Resources and Reminders
Objective

• Provide a better understanding of Podiatry billing guidelines, including routine foot care and other policies

• Reduce paid claims error rate
OIG Study

• Nail debridement is largest paid foot care service

• One in every four claims contained insufficient documentation

• Resulted in inappropriate payments
Recognized Providers for Podiatry

• Doctors of Podiatric Medicine (DPM)
  – Within scope of practice
  – Consider “physician services”

• MD, DO, NPP
  – May perform podiatry services
  – Within scope of practice

• IOM 100-01 Chapter 5, § 70.3
General Podiatry Coverage

• **Initial** diagnostic services
• Treatment beyond initial examination
  – Not covered for routine diagnoses
  – For diabetes-related nerve damage
    • Exam once every 6 months
  – Non-traumatic amputation services
    • Change of appearance
    • Additional frequency may be covered
General Podiatry Coverage

• Injury treatment or foot disease
  – Medically necessary is key
  – Hammer toe
  – Bunion deformities
  – Heel spurs
## Non Covered Supplies

<table>
<thead>
<tr>
<th>Non Covered Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arch Supports</td>
</tr>
<tr>
<td>Elastoplast Wrap</td>
</tr>
<tr>
<td>Heel Cups, Lifts, Pads, Liners</td>
</tr>
<tr>
<td>Jobst or Support Hose</td>
</tr>
</tbody>
</table>
Coverage

- Legally authorized to perform under Federal and State guidelines
  - Consistent with scope of practice
  - MD, DO, NPP, DPM

- Reasonable and necessary services
Excluded Services

• Treatment of flat foot

• Treatment of subluxation of the foot

• Supportive devices for the foot
Excluded Services

• Routine foot care
  – Cutting or removal of corns/calluses
  – Trimming, cutting, clipping or debriding of nails
  – Hygienic and preventive maintenance care

• Exceptions apply
Routine Foot Care Exceptions

- Part of covered services
- Treatment of warts
- Presence of Systemic Condition
Routine Foot Care

• “At Risk” requirement: Patient exposed to significant risk if routine foot care is rendered by anyone other than:
  – DPM
  – MD
  – DO
  – NPP
Systemic Condition Examples

• Diabetes mellitus*
• Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
• Buerger’s disease (thromboangiitis obliterans)
• Chronic thrombophlebitis *
Systemic Condition Examples

- Peripheral neuropathies involving the feet
  - Associated with malnutrition and vitamin deficiency *
    - Malnutrition (general, pellagra)
    - Alcoholism
    - Malabsorption (celiac disease, tropical sprue)
    - Pernicious anemia
Systemic Condition Examples

– Associated with carcinoma *
– Associated with diabetes mellitus *
– Associated with drugs and toxins *
– Associated with multiple sclerosis *
– Associated with uremia (chronic renal disease) *
Systemic Condition Examples

- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders
  - Hereditary sensory radicular neuropathy
  - Angiokeratoma corporis diffusum (Fabry’s)
  - Amyloid neuropathy

- *Active care of doctor required*
Routine Foot Care

• Active care of physician
  – Treatment and/or evaluation of complicating disease during six month period prior to rendition of routine foot care

IOM- 100-2 Chapter 15 Section 290(F)
Routine Foot Care

• “At Risk” requirement
  – Problems related to infection, prolonged bleeding, and/or impaired wound healing
  – Could lead to complications and potential loss of limb
  – Asterisked condition (*) requires active care of Doctor of Medicine or Osteopathy
Routine Foot Care

• Non-asterisked Conditions
  – Do not require active care of physician
  – Neuropathic (e.g. Leprosy)
  – Vascular (e.g. Lipidoses)
    • “Q” modifier
Routine Foot Care

• Class A Finding
  – Nontraumatic amputation of foot or integral skeletal portion thereof
Routine Foot Care

• Class B Findings
  – Absent posterior tibial pulse
  – Absent dorsalis pedis pulse
  – Three advanced trophic changes
Routine Foot Care

• Class C Findings
  – Claudication
  – Temperature changes
  – Edema
  – Paresthesias
  – Burning
Routine Foot Care

• Routine foot care
  – Once every 60 days
    • Document medical necessity of more frequent services
  – Bill in date order
  – Use modifier “GY” if billing for denial
Evaluation and Management (E/M)

- New patient visit
  - Three year time frame
- Routine foot care ≠ E/M
- Documentation must support billed service(s)
- No need for Modifier 25
Evaluation and Management (E/M)

- Not covered for history/physical admission
  - Hospital, nursing home or skilled nursing facility (SNF) history/physical admission
  - Above admissions not within scope of Podiatry licensure
Debridement of Nails

• Reduction of nail thickness *and* length required
• Do not use debridement codes for trimming of nails
• Rule of thumb – covered once every 60 days
Mycotic Nails

• Covered only for debridement of mycotic nails that cause an acute condition
  – Requires thinning of toenail to normal thickness
  – Rule of thumb – covered once every 60 days
Mycotic Nails

• Ambulatory patient
  – Clinical evidence of mycosis of the toenail
  – Limitation of ambulation, pain or secondary infection
Mycotic Nails

• Non ambulatory patient
  – Clinical evidence of mycosis of toenail
  – Pain or secondary infection
Billing Requirements
Routine Foot Care

• Modifier usage
  – Q7 - One Class A finding
  – Q8 - Two Class B findings
  – Q9 - One Class B and 2 Class C findings
Billing Requirements

• Item 17 - Ordering/referring physician name
• Item 17a - Ordering/referring NPI
• Item 19
  – Routine foot care claims
  – Date last seen by attending
CMS 1500 Form Instructions

• Item 17
  – Enter qualifier
    • DN = Referring Provider
    • DK = Ordering Provider
    • DQ = Supervising Provider
CMS 1500 Form Instructions

- Item 17
  - Physician’s name
- Item 17 B
  - Physician’s NPI (Type 1)
CPT Codes - Lesions

• Paring or cutting of benign or hyperkeratotic lesion
  – 11055 - single lesion
  – 11056 - two to four
  – 11057 - more than four

• Units field = “1”
  – CMS 1500 – Item 24 G
  – EDI – Loop 2400, Segment SV104
CPT Codes - Debridement

• Debridement of nail(s) by any method
  – 11720 - one to five
  – 11721 - six or more

• Units field = 1
  – CMS 1500 – Item 24 G
  – EDI – Loop 2400, Segment SV104
CPT Codes - Trimming

- 11719 - Trimming of nondystrophic nails, any number
- G0127 - Trimming of dystrophic nails, any number

- Units field = 1
  - CMS 1500 – Item 24 G
  - EDI – Loop 2400, Segment SV104
National Correct Coding Initiative and Podiatry
Procedures Bundling into G0127 and 11719

• E/M
• Debridement of tissue
• Suturing
• Injections
• Nerve blocks

*Not all inclusive
Procedures Bundling into 11055 - 11057

- E/M
- Debridement of tissue
- Suturing
- Trimming
- Destruction of lesions
- Nerve blocks

*Not all inclusive
NCCI Edits
http://www.cms.gov/Medicare/Medicare.html
National Correct Coding Initiative Edits

Important notice to all NCCI Users concerning the National Correct Coding Initiative Policy Manual for Medicare Services:

The annual updated version of the National Correct Coding Initiative Policy Manual for Medicare Services was effective August 2016. References to the manual have been italicized in red font.

National Correct Coding Initiative

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI Procedure-to-Procedure (PTP) edits within their claim processing systems for dates of service on or after January 1, 1996 and began implementing Medically Unlikely (MUE) edits on January 1, 2007.

A corresponding set of PTP edits is incorporated into the outpatient code editor (OCE) for OPPS and therapy providers (Part B), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy and speech-language pathology providers (OPTs), and certain claims for home health agencies (HHAs) billing under TOBs 22X, 23X, 75X, 74X, 34X. Corresponding MUE edits are similarly implemented within the Fiscal Intermediary Shared System (FISS).
Select “Practitioner PTP Edits”

Outpatient PTP used in OCE - Effective April 1, 2012 the change was implemented on the CMS website where a single Column One/Column Two Correct Coding edit file contains all active NCCI edits and deleted NCCI edits that previously were contained in the OPPS Mutually Exclusive and Column One/Column Two Correct Coding edit files. **These edits** were not deleted from the OCE NCCI files but were moved to the Column One/Column Two Correct Coding edit file.

As of October 8, 2014, the PTP text files have been modified for 508 compliancy purposes. They now include headers and are tab delimited.

**Related Links**

- Hospital PTP Edits v22.0 effective January 1, 2016 (662,040 records). The last row contains edits column 1 = 39599 and column 2 = 49570.
- Hospital PTP Edits v22.0 effective January 1, 2016 (596,425 records). The first row contains edits column 1 = 40490 and column 2 = 0213T.
- Practitioner PTP Edits v22.0 effective January 1, 2016 (903,287 records). The last row contains edits column 1 = 39599 and column 2 = 49570.
- Practitioner PTP Edits v22.0 effective January 1, 2016 (866,823 records). The first row contains edits column 1 = 40490 and column 2 = 00170.
### NCCI Column 1/Column 2 Table

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<thead>
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<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
<th>PTP Edit Rationale</th>
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<tbody>
<tr>
<td>11042</td>
<td>11001</td>
<td>19960101</td>
<td>19960101</td>
<td>9</td>
<td>Standards of medical / surgical practice</td>
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<tr>
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<td>11010</td>
<td>19980101</td>
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<td>Mutually exclusive procedures</td>
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<td>Mutually exclusive procedures</td>
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<td>HCPCS/CPT procedure code definition</td>
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<td>11100</td>
<td>19970101</td>
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<td>1</td>
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<td>11719</td>
<td>19990401</td>
<td>*</td>
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<tr>
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<td>20121001</td>
<td>*</td>
<td>1</td>
<td>Misuse of column two code with column one code</td>
</tr>
</tbody>
</table>
NCCI Edit Table - Column F
Use of Modifiers

• 0 = Not allowed
  – 2 codes are never payable same patient, same date of service

• 1 = Allowed
  – Bill with modifier
  – Documentation on file

• 9 = Not applicable
Modifiers

• Use anatomical modifier if available
  – T1 – TA
  – RT, LT

• Modifier 25 if applicable, warranted and documented

• Use 59 if necessary
  – Only on NCCI edits
  – Documentation on file
## Digit “T” Modifiers

<table>
<thead>
<tr>
<th>LT – Left Foot</th>
<th>RT – Right Foot</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA</td>
<td>T5</td>
</tr>
<tr>
<td></td>
<td>Great toe</td>
</tr>
<tr>
<td>T1</td>
<td>T6</td>
</tr>
<tr>
<td></td>
<td>Second digit</td>
</tr>
<tr>
<td>T2</td>
<td>T7</td>
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<td>Third digit</td>
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<td>T3</td>
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<td>Fourth digit</td>
</tr>
<tr>
<td>T4</td>
<td>T9</td>
</tr>
<tr>
<td></td>
<td>Fifth digit</td>
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</table>
National Coverage Determinations (NCDs)
Medicare Coverage - General Information

Medicare provides coverage for items and services for over 48 million beneficiaries. The vast majority of coverage is provided on a local level and developed by clinicians at the contractors that pay Medicare claims. However, in certain cases, Medicare deems it appropriate to develop a National Coverage Determination (NCD) for an item or service to be applied on a national basis for all Medicare beneficiaries meeting the criteria for coverage. This page provides general information on various parts of that NCD process, resources of both a general and historical nature, and summaries and support documents concerning several miscellaneous NCDs.

People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.

Related Links

- Medicare Coverage Database
- Medicare Coverage Center
- Medicare Coverage Determination Process

Page last modified: 04/03/2014 8:03 AM
Help with File Formats and Plugins
NCD 270.1

• National Coverage Determination (NCD) for Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds
  – Covered for Chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers only
NCD 70.2.1

• Services provided for the diagnosis and treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS) (aka Diabetic Peripheral Neuropathy)
Published by CMS

• Hyperbaric Oxygen Therapy in Treatment of Hypoxic Wounds
  – Technology assessment (TA)
Local Coverage Determinations (LCDs)
POLICIES

Local Coverage Determination (LCD)
National Coverage Determination (NCD)
Medicare Coverage Database Articles
Investigational Device Exemptions (IDES)
Post Market Studies and Post Market Extension Studies
Self Administered Drugs (SADs)
Coverage Topics Outside NCDs/LCDs

Policies (LCDs and NCDs)

A Local Coverage Determination (LCD) is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide, basis. The LCDs are located on the CMS website in a Medicare Coverage Database (MCD).

- How to Use The Medicare Coverage Database

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device.

Last Updated Sep 15, 2013
Select “Active LCDs”

Active Local Coverage Determinations

The official Local Coverage Determination (LCD) is the version on the Medicare Coverage Database at [www.cms.gov/MCD](http://www.cms.gov/MCD).

- California Northern - Contractor ID 01112
- California Southern - Contractor ID 01182
- Hawaii and Territories - Contractor ID 01212
- Nevada - Contractor ID 01312

View the ICD-9 to ICD-10 LCD number crosswalk.

Each hyperlink from the State/Contract navigates to an external website.

<table>
<thead>
<tr>
<th>Medicare Database Number</th>
<th>LCD Title</th>
<th>Contract</th>
<th>CPT / HCPCS Codes Referenced</th>
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</thead>
<tbody>
<tr>
<td>L34188</td>
<td>Actinic Keratosis</td>
<td>• CA-Northern, CA-Southern, AS, GU, HI, NMI</td>
<td>11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 17000, 17003, 17004, 96567, 37308, 37309</td>
</tr>
</tbody>
</table>
Local Coverage Determination (LCD):
Treatment of Ulcers & Symptomatic Hyperkeratoses (L34243)

Select the ‘Print Complete Record’, ‘Add to Basket’ or ‘Email Record’ buttons to print the record, to add it to your basket or to email the record.

Printing Note:
# Coverage, Indications and Limitations

## CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment only for those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1862(a)(13)(A)(B)(C) of the Act excludes payment for the treatment of flat foot conditions, the treatment of subluxation of the foot, and routine foot care.


CMS On-Line Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 16, §30, states that some foot care is covered and some is excluded.

CMS On-Line Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, §290, clarifies which foot care services are covered and which are excluded from coverage.

CMS On-Line Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §70.2. Consultation services rendered by a podiatrist in a skilled nursing facility are covered if the services are reasonable and necessary and do not come within any of the specific statutory exclusions.


CMS On-Line Manual, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.3, Diagnosis Code Requirements

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

For Medicare purposes, an "ulcer" does not exist until there is a partial thickness skin loss involving epidermis with or without dermis. Some authors will define a "pre-ulcer" condition and others even a "Stage 1 Ulcer" (e.g. "Wagner 1") where the skin is still intact. Such changes do not constitute an "ulcer" for Medicare payment purposes under this policy.

Ulcers may develop because of a combination of ischemia, infection, abscess, trauma, prolonged pressure, repetitive stress, edema, and loss of sensation. Their management includes:

1. Overall medical and surgical treatment of the cause.
2. Meticulous care of the ulcerated skin and other associated soft tissue with application of medications and dressings, and
3. When reasonable and necessary, debridement of the necrotic and devitalized tissue.

The management of a symptomatic hyperkeratosis may involve medical treatment, paring or cutting, shaving, excision, or destruction. This policy addresses only the paring or cutting approach. The other approaches are addressed in the Noridian Skin Lesion (Non-melanoma)/Removal LCD.

This policy does not address treatment of burns or debridment of nails. For treatment of burns, including debridement, refer to the CPT 16000 series. For debridement of nails, refer to CPT codes 11720 and 11721.

When the only service provided is the non-surgical cleansing of the ulcer site with or without the application of a surgical dressing, the provider should bill this service with the appropriate evaluation and management (E/M) code and not a debridment code(s).

CPT codes 11042-11044 describe debridement of relatively localized areas with or without their contiguous underlying structures. These codes are appropriate for treatment of skin ulcers, chronic/chronic thermal infections, conditions affecting contiguous deeper structures, and debridement of normal adhesions such as from road.
List of CPT/HCPCS Affected by the Policy

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99999</td>
<td>Not Applicable</td>
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</tbody>
</table>

CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10060</td>
<td>Drainage of skin abscess</td>
</tr>
<tr>
<td>10061</td>
<td>Drainage of skin abscess</td>
</tr>
<tr>
<td>11042</td>
<td>Deb subq tissue 20 sq cm&lt;</td>
</tr>
<tr>
<td>11043</td>
<td>Deb musc/fascia 20 sq cm&lt;</td>
</tr>
<tr>
<td>11044</td>
<td>Deb bone 20 sq cm&lt;</td>
</tr>
<tr>
<td>11045</td>
<td>Deb subq tissue add-on</td>
</tr>
<tr>
<td>11046</td>
<td>Deb musc/fascia add-on</td>
</tr>
<tr>
<td>11047</td>
<td>Deb bone add-on</td>
</tr>
<tr>
<td>11055</td>
<td>Trim skin lesion</td>
</tr>
<tr>
<td>11056</td>
<td>Trim skin lesions 2 to 4</td>
</tr>
<tr>
<td>11057</td>
<td>Trim skin lesions over 4</td>
</tr>
</tbody>
</table>

ICD-9 Codes that Support Medical Necessity

August 2016
# ICD-10 Codes that Support Medical Necessity

## Group 1 Codes:

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.620*</td>
<td>Type 1 diabetes mellitus with diabetic dermatitis</td>
</tr>
<tr>
<td>E10.621*</td>
<td>Type 1 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E10.622*</td>
<td>Type 1 diabetes mellitus with other skin ulcer</td>
</tr>
<tr>
<td>E10.628*</td>
<td>Type 1 diabetes mellitus with other skin complications</td>
</tr>
<tr>
<td>E10.69*</td>
<td>Type 1 diabetes mellitus with other specified complication</td>
</tr>
<tr>
<td>E11.620*</td>
<td>Type 2 diabetes mellitus with diabetic dermatitis</td>
</tr>
<tr>
<td>E11.621*</td>
<td>Type 2 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E11.622*</td>
<td>Type 2 diabetes mellitus with other skin ulcer</td>
</tr>
<tr>
<td>E11.628*</td>
<td>Type 2 diabetes mellitus with other skin complications</td>
</tr>
<tr>
<td>E11.65*</td>
<td>Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E11.69*</td>
<td>Type 2 diabetes mellitus with other specified complication</td>
</tr>
<tr>
<td>I70.231</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of thigh</td>
</tr>
<tr>
<td>I70.232</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of calf</td>
</tr>
<tr>
<td>I70.233</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of ankle</td>
</tr>
<tr>
<td>I70.234</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot</td>
</tr>
<tr>
<td>I70.235</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of other part of foot</td>
</tr>
<tr>
<td>I70.238</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg</td>
</tr>
<tr>
<td>I70.239</td>
<td>Atherosclerosis of native arteries of right leg with ulceration of unspecified site</td>
</tr>
<tr>
<td>I70.241</td>
<td>Atherosclerosis of native arteries of left leg with ulceration of thigh</td>
</tr>
</tbody>
</table>
Active Policy

• Treatment of Ulcers & Symptomatic Hyperkeratosis
  – JF – L34199
  – JE - L34243
Treatment of Ulcers & Symptomatic Hyperkeratosis

– Pre-ulcer or Stage 1 – not covered
– Policy addresses paring or cutting only
– Non surgical cleansing – bill E/M
– Specific DX criteria applies
  • Multiple DX code may be required
Treatment of Ulcers & Symptomatic Hyperkeratosis

- Indications for debridement
- Specific size and location(s)
- Observed depth and specific depth/level of debridement of ulcer(s)
Diagnosis Reporting – Group 1

• Establish medical necessity

  – “Specified manifestation" = skin ulcer
  – Add 2nd ICD-9 code (L97.111, L97.112, L97.113, L97.114, L97.121, etc) to define ulcer
Diagnosis Reporting
Groups 2 and 3

• Medical Necessity
  – 1 code from L84, L11.0, L85.0, L85.1, L85.2, L87.0, L87.2 or Q81.9, Q82.8 and
  – 1 code from L03.311, L03.312, L03.313, L03.314, L03.315, L03.316 or M79.671, M79.672, M79.674, M79.675

* Use Q81.9, Q82.89 only for hyperkeratotic, symptomatic lesions
  • Painful porokeratosis or keratoderma).
Documentation

• Indications for the debridement
  – Necrotic or devitalized tissue
  – Size, location (specific toe(s)), depth

• Relevant history and physical findings

• Document necessity and coverage criteria for routine foot care
  – 11055, 11056, 11057, G0127, 11719, 11720, 11721
Active Policy

• Removal of benign skin lesions
  – JF – L33979
  – JE – L34233
Removal of Benign Skin Lesions

– Must be medically necessary

– 1 + from following list

A. The lesion has one or more of the following characteristics:
   1. Bleeding
   2. Intense itching
   3. Pain
Removal of Benign Skin Lesions

B. Evidence of inflammation
C. Orifice or vision obstruction
D. Uncertain clinical diagnosis
E. Biopsy or exam suggests malignancy or pre-malignancy
Additional Coverage

• Wart removals
  – Condition A – E above present and documented, and
  – Either
    • Chronic recurrent conjunctivitis
    • Evidence of spreading

• Sebaceous cyst
  – Specific DX criteria apply
  – Not included in the JE policy
Documentation Requirements

- Medical necessity
- Document symptoms and physical findings
- Lesion characteristics
- Provide if requested
JF- Additional Policies to Consider

• L 34076
  – Injections – Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma
JE - Additional Policies to Consider

- L34218 - Injections – Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma
- L34211 - Trigger Point Injections
- L34219 - Noninvasive Peripheral Arterial Studies
- L34229 - Noninvasive Peripheral Venous Studies
Therapeutic Shoes for Persons with Diabetes Policy

- LCD ID  L33369
- Workshop
  - August 31 at 1 p.m. CT, 11 a.m. PT

https://med.noridianmedicare.com/documents/2230715/2240923/Therapeutic+Shoes+for+Persons+with+Diabetes.pdf/b38e068a-ceef-481b-9ae5-1f4794f1a675
Resources and Reminders
Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals
Resources

• Internet Only Manual (IOM)
  – 100-02 Chapter 15 § 290
CEU Reminder

• Attend entire workshop to earn CEU(s)
• Take short polling survey
  – Pops up after closing out of webinar
• CEU emailed 3 days after presentation
  – Earn 1.5 CEUs today
  – No password/index number needed for AAPC
• PDF presentation emailed again with CEU
• Q/A posted after 30 business days
Questions

Thank you