WHAT ARE THE CODES THAT TRIGGER AUDITS IN PODIATRY AND WHAT IS THE APPROPRIATE DOCUMENTATION TO SURVIVE THEM?

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- **KEY FACT: Podiatry has been, and continues to be, a highly audited medical specialty**

Most Commonly Audited Codes in Podiatry

- 11720/11721 (nail debridement)
- E/M Codes – all (-25 modifier)
- 11730 (nail avulsion)
- Wound Care Codes
- 11060/11061 (I&D of abscess)
- 11050 series (paring of skin lesions) (corns/calluses)
- Orthotics Codes
- 59 Modifier
- Injection codes (Morton's neuroma, plantar fascitis)

11720/11721 (Nail Debridement)

Ongoing Confusion Over Qualified Routine Foot Care

- **Mycotic nail coverage rules**
- **Covered routine foot care rules**

Special Podiatric Services

Routine Foot Care:

Routine Foot Care, by definition, is the cutting or removal of corns and calluses, and the trimming, cutting, clipping or debriding of toenails.

For Medicare purposes, this routine treatment of the feet is not a covered service (Non Covered Routine Foot Care). In specific cases, Medicare will pay for this routine treatment (Covered Routine Foot Care). The following text discussed the details of Covered VS. Non-covered Routine Foot Care and how to bill Medicare. There is significant abuse billing Medicare for these routine services.

NOTE: DO NOT BILL ROUTINE FOOT CARE WITH AN E/M CODE

Non-Covered Routine Foot Care:

Medicare does not pay for Routine Foot Care, except in very specific situations. Be aware, you are not required to bill Medicare for any non-covered condition, therefore you do not have to bill Medicare for Routine Foot Care. It is necessary to inform the patient, in advance of any treatment that is not covered. Have the patient sign an "ADVANCE BENEFICIARY NOTICE of NON-COVERAGE" (ABN) which notifies the patient that they are obliged to pay **for the service. If the patient insists that you send a claim to Medicare, bill the appropriate service code (11055, 11056, 11057, 11719, 11720, 11721 or G0127) with the –GA modifier to inform Medicare that this is a Non-covered service. NOTE: Some Medicare Carriers include 11720 and 11721 as appropriate service codes. Be aware** of your MAC/Medicare Carrier Rules. See your Medicare Carrier's LCD for Routine Care.

Covered Routine Foot Care:

When a patient has a specific Systemic Disease (Metabolic, Vascular, or Neurologic Disease), and that patient requires the services of a Physician (DPM, MD, DO), Medicare will pay for Routine Foot Care. In general, Routine Foot Care services will be paid by Medicare if the Patient's Systemic Disease has resulted in the patient having **severe circulatory embarrassment or areas of diminished sensation in their leg or foot. Please refer to the list of the systemic diseases that qualify Routine Foot Care service for Medicare payment in this section of the book.** Medicare commonly refers to these patient's as **"AT RISK" patients.**

Systemic Diseases: Qualifying Routine Foot Care for Payment

Medicare has published a list of Systemic Diseases (in this section of the book) that can cause severe circulatory embarrassment or areas of desensitization in a patient's leg or foot. Medicare has designated several of these **diseases with an "asterisk" (*) to denote that patients with one of these diseases must be under the active care of an MD or DO. Active care means that the MD or DO is treating the patient for that disease and has been seen at least once in the past 6 months for that disease prior to the foot care encounter.This is referred to as the <u>Active Care Requirement.</u>** There are different requirements for billing a patient with an "asterisk" or a "non-asterisk" **disease (which is discussed below). Refer to the Medicare Systemic Disease list in this section of the book and how to bill Medicare for Routine Foot Care on the following pages.**

- **Please refer to the appropriate LCD either "Routine Foot Care" or "Debridement of Mycotic Nails" as published by <u>your</u> Medicare Administrative Carrier (MAC)**

"Asterisk" Systemic Disease:

An "Asterisk" systemic disease simply refers to a disease that Medicare designates the necessity for an MD or DO physician to make the diagnosis and actively treat the patient for that disease. Actively means that the patient has to have been seen by the MD or DO within a 6 month period for that specific disease. This is referred to as the "**Active Care Requirement**." When a Podiatrist provides a routine foot care service (11055, 11056, 11057, 11719, 11720, 11721 or G0127) to a patient with an "asterisk" systemic disease they can bill and be paid by Medicare, but must include specific information in their medical record and on the billing claim form.

Include the following in your medical record:

The treating MD or DO's name
The date last seen by the MD or DO
The systemic disease and associated complication(s) resulting from the disease (These are the Class Findings that lead you to select the appropriate Q modifier)

Include the following on the billing claim from:

The name of the MD or DO treating the systemic disease in Field 19 of the CMS-1500 form
The NPI of the MD or DO treating the systemic disease in Field 19 of the CMS-1500 form
The date last seen by the MD or DO in Field 19 of the CMS-1500 form
*DPM's Podiatric Diagnosis (ICD-9 code) in Field 21, line 1 (Primary Diagnosis)
*The systemic disease (ICD-9 code) of the treating MD or DO in Field 21, line 2 (Secondary Diagnosis)
Use either 11055, 11056, 11057, 11719, 11720, 11721, or G0127 in Field 24d
Use appropriate Q modifier in Field 24d (Q7, Q8, Q9)

"Non-Asterisk" Systemic Disease:

A systemic disease that does not have a Medicare asterisk designated has different requirement for record keeping and billing. The systemic disease diagnosis and subsequent treatment of that systemic disease can be made by the DPM, MD or DO as appropriate. If a DPM is the diagnosing and treating physician for the systemic disease it is absolutely necessary to have adequate medical record documentation to support the diagnosis making decision…and subsequent treatment. The simple indication of a systemic diagnosis without documentation is not adequate. Please note that due to the fact that DPM's are limited scope practitioners, a DPM cannot treat a systemic disease. A DPM can treat the manifestations, complications, or end results of a systemic disease when they appear in the treating area of a DPM, the foot and the ankle.

Include the following in your medical record:

The H & P documentation used to establish the systemic disease diagnosis
The specific systemic disease and plan of treatment
The documentation for the podiatric diagnosis including treatment plan

Include the following on the billing claim from:

The name of the DPM, MD or DO treating the systemic disease in Field 19 of the CMS-1500 form
The NPI of the DPM, MD or DO treating the systemic disease in Field 19 of the CMS-1500 form
*Podiatric diagnosis (ICD-9 code) in Field 21, line 1 (Primary Diagnosis)
*The systemic disease (ICD-9 code) in Field 21, line 2 (Secondary Diagnosis)

ICD-10 Codes that Support Medical Necessity

Group 1 Codes

ICD-10 CODE	DESCRIPTION
A30.0 - A30.9- Opens in a new window	Indeterminate leprosy - Leprosy, unspecified
A52.10	Symptomatic neurosyphilis, unspecified
A52.11	Tabes dorsalis
A52.15*	Late syphilitic neuropathy
A52.16	Charcot's arthropathy (tabetic)
A52.17	General paresis
A52.3	Neurosyphilis, unspecified
D51.0*	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D53.1*	Other megaloblastic anemias, not elsewhere classified
D68.8*	Other specified coagulation defects
D68.9*	Coagulation defect, unspecified
D81.818*	Other biotin-dependent carboxylase deficiency
D81.819*	Biotin-dependent carboxylase deficiency, unspecified
E08.40*	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.42*	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E09.40*	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.42*	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E10.40 - E10.49*- Opens in a new window	Type 1 diabetes mellitus with diabetic neuropathy, unspecified - Type 1 diabetes mellitus with other diabetic neurological complication
E10.51 - E10.59*- Opens in a new window	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene - Type 1 diabetes mellitus with other circulatory complications
E10.610*	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E11.21 - E11.39- Opens in a new window	Type 2 diabetes mellitus with diabetic nephropathy - Type 2 diabetes mellitus with other diabetic ophthalmic complication

E11.40 - E11.610*- Opens in a new window	Type 2 diabetes mellitus with diabetic neuropathy, unspecified - Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E13.21	Other specified diabetes mellitus with diabetic nephropathy
E13.311 - E13.39- Opens in a new window	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema - Other specified diabetes mellitus with other diabetic ophthalmic complication
E13.40 - E13.610*- Opens in a new window	Other specified diabetes mellitus with diabetic neuropathy, unspecified - Other specified diabetes mellitus with diabetic neuropathic arthropathy
E46*	Unspecified protein-calorie malnutrition
E51.11 - E51.12*- Opens in a new window	Dry beriberi - Wet beriberi
E52*	Niacin deficiency [pellagra]
E53.1*	Pyridoxine deficiency
E53.8*	Deficiency of other specified B group vitamins
E64.0*	Sequelae of protein-calorie malnutrition
E75.21	Fabry (-Anderson) disease
E75.22	Gaucher disease
E75.240 - E75.249- Opens in a new window	Niemann-Pick disease type A - Niemann-Pick disease, unspecified
E75.3	Sphingolipidosis, unspecified
E77.0 - E77.9- Opens in a new window	Defects in post-translational modification of lysosomal enzymes - Disorder of glycoprotein metabolism, unspecified
E85.1 - E85.9- Opens in a new window	Neuropathic heredofamilial amyloidosis - Amyloidosis, unspecified
G11.1	Early-onset cerebellar ataxia
G13.0*	Paraneoplastic neuromyopathy and neuropathy
G13.1*	Other systemic atrophy primarily affecting central nervous system in neoplastic disease
G35*	Multiple sclerosis
G60.0 - G60.9- Opens in a new window	Hereditary motor and sensory neuropathy - Hereditary and idiopathic neuropathy, unspecified
G61.0*	Guillain-Barre syndrome
G61.1*	Serum neuropathy
G62.0 - G62.2*- Opens in a new window	Drug-induced polyneuropathy - Polyneuropathy due to other toxic agents
G62.82*	Radiation-induced polyneuropathy

G63*	Polyneuropathy in diseases classified elsewhere
G65.0 - G65.2*- Opens in a new window	Sequelae of Guillain-Barre syndrome - Sequelae of toxic polyneuropathy
G70.1*	Toxic myoneural disorders
G73.3*	Myasthenic syndromes in other diseases classified elsewhere
I70.201 - I70.269- Opens in a new window	Unspecified atherosclerosis of native arteries of extremities, right leg - Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity
I73.00 - I73.1- Opens in a new window	Raynaud's syndrome without gangrene - Thromboangiitis obliterans [Buerger's disease]
I74.3 - I74.4- Opens in a new window	Embolism and thrombosis of arteries of the lower extremities - Embolism and thrombosis of arteries of extremities, unspecified
I80.00 - I80.299*- Opens in a new window	Phlebitis and thrombophlebitis of superficial vessels of unspecified lower extremity - Phlebitis and thrombophlebitis of other deep vessels of unspecified lower extremity
K90.0 - K90.3*- Opens in a new window	Celiac disease - Pancreatic steatorrhea
K91.2*	Postsurgical malabsorption, not elsewhere classified
M05.50 - M05.59*- Opens in a new window	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site - Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites
M30.0	Polyarteritis nodosa
M30.2	Juvenile polyarteritis
M30.8	Other conditions related to polyarteritis nodosa
M31.4*	Aortic arch syndrome [Takayasu]
M31.7	Microscopic polyangiitis
M34.83*	Systemic sclerosis with polyneuropathy
N18.1 - N18.9*- Opens in a new window	Chronic kidney disease, stage 1 - Chronic kidney disease, unspecified
N19*	Unspecified kidney failure

S14.0XXA - S14.159S- Opens in a new window	Concussion and edema of cervical spinal cord, initial encounter - Other incomplete lesion at unspecified level of cervical spinal cord, sequela
S24.0XXA - S24.159S- Opens in a new window	Concussion and edema of thoracic spinal cord, initial encounter - Other incomplete lesion at unspecified level of thoracic spinal cord, sequela
S34.01XA - S34.4XXS- Opens in a new window	Concussion and edema of lumbar spinal cord, initial encounter - Injury of lumbosacral plexus, sequela
S74.00XA - S74.92XS- Opens in a new window	Injury of sciatic nerve at hip and thigh level, unspecified leg, initial encounter - Injury of unspecified nerve at hip and thigh level, left leg, sequela
S84.00XA - S84.92XS- Opens in a new window	Injury of tibial nerve at lower leg level, unspecified leg, initial encounter - Injury of unspecified nerve at lower leg level, left leg, sequela
S94.00XA - S94.92XS- Opens in a new window	Injury of lateral plantar nerve, unspecified leg, initial encounter - Injury of unspecified nerve at ankle and foot level, left leg, sequela

Group 2 Codes

ICD-10 CODE	DESCRIPTION
E11.51 - E11.59*- Opens in a new window	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene - Type 2 diabetes mellitus with other circulatory complications
I70.201 - I70.249- Opens in a new window	Unspecified atherosclerosis of native arteries of extremities, right leg - Atherosclerosis of native arteries of left leg with ulceration of unspecified site
I70.261 - I70.269- Opens in a new window	Atherosclerosis of native arteries of extremities with gangrene, right leg - Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity
I73.00 - I73.1- Opens in a new window	Raynaud's syndrome without gangrene - Thromboangiitis obliterans [Buerger's disease]
I74.3	Embolism and thrombosis of arteries of the lower extremities
M30.0	Polyarteritis nodosa
M30.2	Juvenile polyarteritis
M30.8	Other conditions related to polyarteritis nodosa
M31.4*	Aortic arch syndrome [Takayasu]
M31.7	Microscopic polyangiitis

Group 3 Codes

The following diagnoses related to peripheral neuropathy do *not* require a Q modifier:

ICD-10 CODE	DESCRIPTION
A30.0 - A30.9- Opens in a new window	Indeterminate leprosy - Leprosy, unspecified
A52.10	Symptomatic neurosyphilis, unspecified
A52.11	Tabes dorsalis
A52.15*	Late syphilitic neuropathy
A52.16	Charcot's arthropathy (tabetic)
A52.17	General paresis
A52.3	Neurosyphilis, unspecified
D51.0*	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D53.1*	Other megaloblastic anemias, not elsewhere classified
D81.818*	Other biotin-dependent carboxylase deficiency
D81.819*	Biotin-dependent carboxylase deficiency, unspecified
E08.40*	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.42*	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E09.40*	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.42*	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E10.40 - E10.49* - Opens in a new window	Type 1 diabetes mellitus with diabetic neuropathy, unspecified - Type 1 diabetes mellitus with other diabetic neurological complication
E10.610*	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E11.21 - E11.39- Opens in a new window	Type 2 diabetes mellitus with diabetic nephropathy - Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.40 - E11.49* - Opens in a new window	Type 2 diabetes mellitus with diabetic neuropathy, unspecified - Type 2 diabetes mellitus with other diabetic neurological complication
E11.610*	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E13.40 - E13.49* - Opens in a new window	Other specified diabetes mellitus with diabetic neuropathy, unspecified - Other specified diabetes mellitus with other diabetic neurological complication
E13.610*	Other specified diabetes mellitus with diabetic neuropathic arthropathy

E46*	Unspecified protein-calorie malnutrition
E51.11 - E51.12*- Opens in a new window	Dry beriberi - Wet beriberi
E52*	Niacin deficiency [pellagra]
E53.1*	Pyridoxine deficiency
E53.8*	Deficiency of other specified B group vitamins
E64.0*	Sequelae of protein-calorie malnutrition
E75.21	Fabry (-Anderson) disease
E75.22	Gaucher disease
E75.240 - E75.249- Opens in a new window	Niemann-Pick disease type A - Niemann-Pick disease, unspecified
E75.3	Sphingolipidosis, unspecified
E77.0 - E77.9- Opens in a new window	Defects in post-translational modification of lysosomal enzymes - Disorder of glycoprotein metabolism, unspecified
E85.1 - E85.9- Opens in a new window	Neuropathic heredofamilial amyloidosis - Amyloidosis, unspecified
G11.1	Early-onset cerebellar ataxia
G13.0*	Paraneoplastic neuromyopathy and neuropathy
G13.1*	Other systemic atrophy primarily affecting central nervous system in neoplastic disease
G35*	Multiple sclerosis
G60.0 - G60.9- Opens in a new window	Hereditary motor and sensory neuropathy - Hereditary and idiopathic neuropathy, unspecified
G61.0*	Guillain-Barre syndrome
G61.1*	Serum neuropathy
G62.0 - G62.2*- Opens in a new window	Drug-induced polyneuropathy - Polyneuropathy due to other toxic agents
G62.82*	Radiation-induced polyneuropathy
G63*	Polyneuropathy in diseases classified elsewhere
G65.0 - G65.2*- Opens in a new window	Sequelae of Guillain-Barre syndrome - Sequelae of toxic polyneuropathy

G70.1*	Toxic myoneural disorders
G73.3*	Myasthenic syndromes in other diseases classified elsewhere
I80.00 - I80.299*- Opens in a new window	Phlebitis and thrombophlebitis of superficial vessels of unspecified lower extremity - Phlebitis and thrombophlebitis of other deep vessels of unspecified lower extremity
K90.0 - K90.3*- Opens in a new window	Celiac disease - Pancreatic steatorrhea
M05.50 - M05.59*- Opens in a new window	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site - Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites
M34.83*	Systemic sclerosis with polyneuropathy
N18.1 - N19*- Opens in a new window	Chronic kidney disease, stage 1 - Unspecified kidney failure
S14.0XXA - S14.159S- Opens in a new window	Concussion and edema of cervical spinal cord, initial encounter - Other incomplete lesion at unspecified level of cervical spinal cord, sequela
S24.0XXA - S24.159S- Opens in a new window	Concussion and edema of thoracic spinal cord, initial encounter - Other incomplete lesion at unspecified level of thoracic spinal cord, sequela
S34.01XA - S34.4XXS- Opens in a new window	Concussion and edema of lumbar spinal cord, initial encounter - Injury of lumbosacral plexus, sequela
S74.00XA - S74.92XS- Opens in a new window	Injury of sciatic nerve at hip and thigh level, unspecified leg, initial encounter - Injury of unspecified nerve at hip and thigh level, left leg, sequela
S84.00XA - S84.92XS- Opens in a new window	Injury of tibial nerve at lower leg level, unspecified leg, initial encounter - Injury of unspecified nerve at lower leg level, left leg, sequela
S94.00XA - S94.92XS- Opens in a new window	Injury of lateral plantar nerve, unspecified leg, initial encounter - Injury of unspecified nerve at ankle and foot level, left leg, sequela

Group 4 Codes

The following diagnosis related to anticoagulation therapy does not require a Q modifier:

ICD-10 CODE	DESCRIPTION
D68.8*	Other specified coagulation defects
D68.9*	Coagulation defect, unspecified

What about 443.9?

- **ICD-9 code 443.9 Peripheral vascular disease, unspecified**
- **ICD-10 crosswalk is I73.9 Peripheral vascular disease, unspecified**
- **Can we still use this diagnosis code?**

Podiatric Diagnosis Codes
ICD-10

- **B35.1 Dermatophytosis of nail**
- **L60.2 onychogryphosis, hypertrophic nails**
- **L60.3 nail dystrophy**
- **L60.8 other nail disorders**
- **L60.9 nail disorder, unspecified**
- **Q84.5 onychauxis, enlarged nails**
- **Q84.6 other cong. Nail dz**
- **L84 Corns and callosities**

Medicare has provided a guide to what is considered minimal documentation necessary to justify the establishment of a systemic vascular disease diagnosis. This documentation referred to as the "Class Findings" is published in Section 4120.1 of the Medicare Carriers Manual. (Duplicated below)

Class Findings:

Medicare established its "Class Findings" documentation to assist Medicare Carriers in trying to determine the appropriateness of Podiatrist's billing for Covered Routine Foot Care. That document has become a simplified guide for Podiatrists to make sure they can justify billing and getting paid for routine services. Medicare Carriers have been directed to require that the "Class Finding" information be indicated on the HCFA-1500 claim form in the form of a modifier (-Q7, -Q8, or –Q9). Make sure that any documentation you have in your Medical record to justify the establishment of a systemic Vascular Disease contains the appropriate finding below:

Class A Findings: Use –Q7 on claim form if there is a Class A finding

Non-traumatic amputation of a foot or an integral skeletal part of the foot.

Class B Findings: Use –Q8 on claim form if there are 2 Class B findings

The absence of a Posterior Tibial pulse (absence of the pulse means non-palpable) - 1 Class B Finding

The absence of a Dorsalis Pedis pulse (absence of the pulse means non-palpable) – 1 Class B Finding

Both Posterior Tibial pulses are non-palpable – 1 Class B finding

Both Dorsalis Pedis pulses are non-palpable – 1 Class B finding

In order to achieve 2 Class B Findings via non-palpable pedal pulses, the 2 non-palpable pulses must be non-palpable on the same foot (ie. non-palpable DP AND non-palpable PT pulses on the right foot)

Three of the following advanced trophic changes such as:

- Hair growth decreased or absent
- Nail changes
- Pigmentary changes
- Skin texture thin and shiny
- Skin color rubor or reddened

Class C Findings: Use –Q9 on claim form if there is 1 Class B & 2 Class C findings

Claudication

Temperature changes (code feet)

Edema

Paresthesias

Burning

MYCOTIC NAIL DEBRIDEMENT

Routine Foot Care Exception	Otherwise Healthy Individual
1. Class Findings	1. No Class Findings
2. Systemic Disease	2. No Systemic Disease
3. Mycotic/Fungal Toenails	3. Mycotic/Fungal Toenails
4. The Mycotic Toenails DO NOT Have to be Symptomatic	4. Symptomatology

MYCOTIC NAIL DEBRIDEMENT

Medicare considers the treatment of Mycotic Nails a covered service only in very specific limited situations. The presence of a fungus infection of the nail does not automatically qualify for Medicare payment. The fungus infection in the nail must be causing the nail to be abnormally thick or dystrophic, and that thick/dystrophic nail must in turn be causing either pain, or a secondary infection or be causing a marked limitation of ambulation for the patient.

IMPORTANT:

UNLESS THE FUNGUS INFECTION IN A NAIL REQUIRES DEBRIDEMENT BECAUSE IT CAUSED THE NAIL TO BE ABNORMALLY THICK WHICH RESULTED IN EITHER PAIN OR A SECONDARY INFECTION OR A MARKED LIMITATION OF WALKING, THE TREATMENT SERVICE IS CONSIDERED SIMPLY A NAIL TRIMMING AND IS NOT PAYABLE BY MEDICARE.

MYCOTIC NAIL SERVICES ARE PAYABLE IF.....

FOR AN AMBULATORY PATIENT:

The Patient must have a marked limiting of walking due to the thickness of the fungus nail.

OR

The Patient must suffer from pain due to the thickness of the fungus nail.

OR

The Patient must suffer from a secondary infection due to the thickness of the fungus nail

AND

There must be documented clinical findings to substantiate the fungus diagnosis

FOR A NON-AMBULATORY PATIENT:

The Patient must suffer from pain due to the thickness of the fungus nail.

OR

The Patient must suffer from a secondary infection due to the thickness of the fungus nail

AND

There must be documented clinical findings to substantiate the fungus diagnosis

INCLUDE THE FOLLOWING IN YOUR MEDICAL RECORD:

Medicare requires adequate documentation to allow payment for Mycotic Nail services. Clearly indicate in your Medical Record the following information:

1.) PAIN **and/or**
2.) SECONDARY INFECTION **and/or**
3.) MARKED LIMITATION OF AMBULATION **and**
4.) CLINICAL FINDINGS INDICATION THE FUNGUS INFECTION
   i.e. Positive fungus culture
   Positive KOH
   Measurement of thickness
   Coloration, odor, texture, subungal debris
5.) ACTIVE TREATMENT PLAN

CPT Codes

- **11720 Debridement of nail(s) by any method(s); 1 to 5**
- **11721 Debridement of nails by any method(s); 6 or more**

ICD-10 Codes

- **B35.1 Dermatophytosis of nail**
- **M79.674 Pain in right toe(s)**
- **M79.675 Pain in left toe(s)**
- **R26.2 Difficulty in walking, not elsewhere classified**
- ***L03.031 Cellulitis of right toe(s)**
- ***L03.032 Cellulitis of left toe(s)**
  - ***ICD-9 cross walk for paronychia**

E/M Codes – all (-25 modifier)

Evaluation and Management Codes with “25” Modifiers

- Number one audit issue
- This issue was included in the Office of Inspector General (OIG) Work Plan for 2004 and 2005.
- Modifier 25 indicates that a SIGNIFICANT, separately identifiable E&M service was performed during the same encounter that a minor surgical procedure was performed.

Evaluation and Management Codes with “25” Modifiers

- **There is not a requirement that two or more diagnosis codes be used in the billing of the services**
  Very subjective as to what is considered “significant”.

E/M Services

1. E/M is **NOT** a synonym for an office visit.
2. It is a **2** part process:

a."**E**" stands for **EVALUATION**. Using the appropriate level of **History, Physical Examination**, and **Medical Decision Making**, you formulate a **WORKING DIAGNOSIS**. This shows **MEDICAL NECESSITY.**

b. "**M**" stands for management. Using the working diagnosis, you now have to do something about it. In other words, you have to **TREAT THE PROBLEM.** Diagnosing a problem is not sufficient.

3. Time should **NEVER** BE A MAJOR FACTOR IN FORMULATING THE APPROPRIATE LEVEL OF E/M SERVICE. Podiatrists are limited scope practitioners. "Time is **NEVER** on your side."

Step 3- Determine Level of Exam
General Multi-system Exam

(For single system, refer to HCFA "Documentation guidelines for Evaluation and Management Services")

System/Body Area	Elements/Bullets
▫Constitutional	▫ Measuring any 3 of the following 7 vital signs 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity 4) respiration, 5) temperature, 6) height, 7) weight(may be measured and recorded by ancillary staff) ▫ General appearance of patient (e.g., development, nutrition, body, habitus, deformities, attention to grooming)
▫ Eyes	▫ Inspection of conjunctives and lids ▫ Examination of pupils and irises (e.g., reaction to light an accommodation, size, and symmetry) ▫ Opthalmoscopic examination of optic discs e.g., size, C?D, ration, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
▫ Ears, Nose, Mouth and Throat (ENMT)	▫ External inspection of ears and nose (e.g. overall appearance, scars, lesions, masses) ▫ Otoscopic examination of external auditory canals and lymphatic membranes ▫Assessment of hearing (e.g. whispered voice, finger rub, tuning fork) ▫ Inspection of nasal mucosa, septum and turbinates ▫ Inspection of lips, teeth and gums ▫ Examination of oropharynx (e.g., oral mucosa, hard and soft palate, tongue, tonsils, posterior pharynx and salivary glands)
▫ Neck	▫ Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, creptus) ▫ Examination of thyroid (e.g., enlargement, tenderness, mass)
▫ Respiratory	▫ Assessment of respiratory effort (e.g., intercostal retractions, use of assessor muscles, diaphragmatic movement) ▫ Percussion of chest (e.g., dullness, flatness, hyperresonance) ▫ Palpation of chest (e.g., tactile fremitus) ▫ Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
▫ Cardiovascular	▫ Palpation of heart (e.g. ,location, size, thrills) ▫ Auscultation of heart with notation of abnormal sounds and murmurs Examination of: ▫ carotid arteries (e.g., pulse amplitude, bruits) ▫ abdominal aorta (e.g., size, bruits) ▫ femoral arteries (e.g., pulse amplitude, bruits) ▫ pedal pulses (e.g., pulse amplitude) ▫ extremities for edema and/or varicosities
▫ Chest (Breasts)	▫ Inspection of breasts (e.g., symmetry, nipple discharge) ▫ Palpation of breasts and axillae (e.g. masses or lumps, tenderness)
▫ Gastrointestinal (abdomen)	▫ Examination of abdomen with notation of presence of masses or tenderness ▫ Examination of liver and spleen ▫ Examination for presence or absence of hernia ▫ Examination (when indication) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses ▫ Obtain stool sample for occult blood test when indicated
Genitourinary (male)	▫ Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) ▫ Examination of the penis ▫ Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
▫ Genitourinary (Female)	Pelvic Examination (with or without specimen collection for smears and cultures) including: ▫ Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) ▫ Examination of urethra (e.g., masses, tenderness, scarring) ▫ Examination of bladder (e.g., fullness, masses, tenderness) ▫ Cervic (e.g., general appearance, lesions, discharge) ▫ Uterus e.g., size contour, position, mobility, tenderness, consistency, descent, or support) ▫ Adnexa/paremetria (e.g., masses, tenderness, organomegaly, nodularity)
▫ Lymphatic	Palpation of lymph nodes in two or more areas: ▫ Neck ▫ Axillae ▫ Groin ▫ Other
▫ Muscoskeletal	▫ Examination of gait and station ▫ Inspection and/or palpitation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petsciae, ischemia, infections, nodes) ▫ Examination of joints, bones, and muscles of one or more of the following six areas: 1) head and neck, 2) spine, ribs, and pelvis, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, and 6) left lower extremity. The examination of a given area includes; inspection, and/or palpitation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ▫ Assessment of range of motion with notation of any pain, crepitation or contracture ▫Assessment of stability with notation of any dislocation (luxation), subluxation or laxity ▫ Assessment of muscle strength and tone e.g., flaccid, cog wheei, spastic) with notation of any atrophy of abnormal movements.
▫ Skin	▫ Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) ▫ Palpitation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
▫ Neurologic	▫ Test cranial nerves with notation of any deficits ▫ Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) ▫ Examination of sensation (e.g., by touch, pin, vibration, proprioception)
Psychiatric	▫ Description of patient's judgment and insight Brief assessment of mental status including: ▫ orientation to time, place and person ▫ recent and remote memory ▫ mood and affect (e.g., depression, anxiety, agitation)

B	Exam Level	▫ Problem Focused- one to five elements identified by a bullet	▫ Expanded Problem Focused- at least 6 elements identified by a bullet	▫Detailed- at least 2 elements identified by a bullet from each of 6 areas/systems OR at least 12 elements identified by a bullet in 2 or more areas/systems	▫ Comprehensive- perform all elements identified by a bullet in at least 1 organ system or body area and document at least 2 elements identified by a bullet from each of 9 areas/systems

Uses of the 25 Modifier

- The 25 Modifier is used to demonstrate that a **SIGNIFICANT, SEPARATELY IDENTIFIABLE** E/M service was performed on the **SAME** day of a **MINOR** surgical procedure by the **SAME** physician.

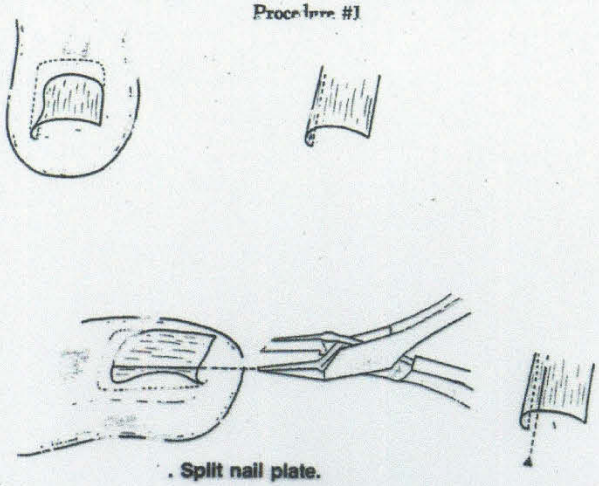
1. Only used on an E/M service
2. An INITIAL E/M service CAN be billed when performed on the SAME date of service as a minor surgical procedure code
   *The diagnosis code for the initial E/M service and the diagnosis code for the minor surgical procedure CAN be the SAME.
3. An ESTABLISHED patient E/M code CAN be billed when performed on the same date of service as a minor surgical procedure code
   *The diagnosis code for the established E/M service MUST be DIFFERENT from the diagnosis code for the minor surgical procedure.
   * There can be NO correlation between the E/M service and the minor surgical procedure.
4. Exception to #3
   **If an established patient is seen for a NEW problem that the patient has never been evaluated for previously, and a minor surgical procedure is performed on the SAME date of service, then not only can BOTH the established patient E/M service code AND the minor surgical procedure code be billed for, but the diagnosis code for the E/M service AND the diagnosis code for the minor surgical procedure can be the SAME
   ***Of course this needs to be documented in the medical record.

Partial or Total Nail Avulsions

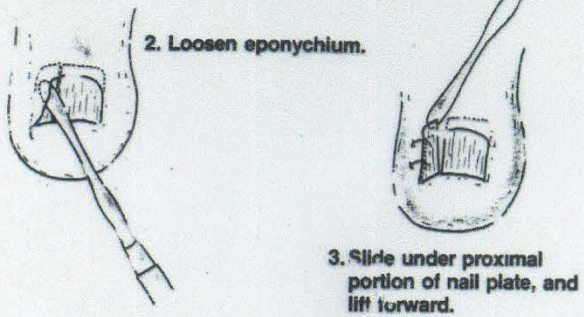
Partial or Total Nail Avulsions

- **Documentation must describe the symptoms and complaint which establish medical necessity for the treatment.**
- **Nail or Nail border must be separated and removed to and under the eponychium.**
- **Local anesthetic (type and quantity) must be documented. If not used, provide rationale (Neuropathic patient, patient refused, medical contraindications)**

Procedure #1



. Split nail plate.



2. Loosen eponychium.

3. Slide under proximal portion of nail plate, and lift forward.

Partial or Total Nail Avulsions

- Post-operative instructions and follow-up care should be documented
- If medial and lateral border are separated or removed on the same nail, only one service can be billed
- Cannot bill an I&D and avulsion or partial avulsion on the same nail

Wound Care Codes

- **Please refer to the appropriate LCD "Wound Debridement Services" or "Debridement of Wounds" as published by your Medicare Administrative Carrier (MAC)**

YOU ARE NO LONGER REIMBURSED PER WOUND/ULCER/LESION

- **The key phrase is now <u>20 SQUARE CENTIMETERS</u>
- *This is PER DEPTH OF DEBRIDEMENT, PER BODY
- *Anatomical modifiers are no longer used
- To demonstrate that different depths of debridement were used, the 59 modifier is used

97597

- **Debridement (eg high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

97598

- **Each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

- **The global period for both 97597 and 97598 is “ 0 “ days**

11042

- **Change in description of the code:**
- **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less**
- **Global period remains “ 0” days**

New Code Effective for 2011

- **11045**
- **Each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**
- **Global period is “ 0 “ days**

11043

- **Change in the description of the code**
- **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less**
- **Global period is “ 0 “ days**

11043

- **Unless the patient has a peripheral neuropathy, a neurological disorder, or is neuropathic, local or general anesthesia is needed**
- **Most if not all Medicare Administrative Carriers expect this procedure to be performed in an ASC or in the hospital**

New Code Effective for 2011

- **11046**
- **Each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**
- **Global period is “ 0 “ days**

11044

- **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less**

- **Global period is “ 0 “ days**

11044

- **Unless the patient has a peripheral neuropathy, a neurological disorder, or is neuropathic, local or general anesthesia is needed**
- **Most if not all Medicare Administrative Carriers expect this procedure to be performed in an ASC or in the hospital**

New Code Effective for 2011

- **11047**
- **Each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**
- **Global period is “ 0 “ days**

Medical Record Documentation

- 1. **Indicate the size, depth, grade, and appearance of the wound or ulcer. This is done on every encounter.**
- **2. Indicate the type of tissue or material removed from the wound or ulcer. The tissue or material must be necrotic. This is the sole factor that determines the debridement code.**
- **3. Chart the location of the wound or ulcer. This is the only time in the process that the location is stated.**
- **4. Indicate any anesthesia (or lack of need) used during the debridement. This is imperative for 11043 or 11044.**

Medical Record Documentation

- **5. Indicate any associated status factors that may affect treatment: ie:**
- **compromised wound oxygenation**
- **Length of time wound present**
- **Localized pressure affecting wound**
- **Proximal arterial obstruction**
- **Venous stasis disease**
- **Pulmonary disease, immune disorder**
- **Wound infection or hygiene**
- **Local edema**

Medical Record Documentation

- Poor nutrition
- Small vessel ischemia
- Diabetes, collagen disease
- Heart failure, anemia
- Need for additional consultation

Note 1: Anticipate (per CMS)

- 1. Most wounds will heal within 4 or fewer debridements
- 2. The more extensive wounds or ulcers only require 1 debridement every 1 – 2 weeks
- 3. Most wounds heal within 16 weeks
- 4. If necrotic muscle or bone are excisionally debrided anesthesia is required or a reason why it was not needed

Therefore: Debridement services that are in excess of 4 per wound or debridement services for multiple or recurrent ulcers or wounds should be clearly documented as to Medical Necessity. The use of a secondary diagnosis to indicate any associated status factors may reduce the chance of denial or review. With ICD-10 this is imperative.

Note 2: Consider

- **1. Pathology report for some lesions**
- **2. A photographic history of the lesion(s). This is the best supplemental documentation that you can have.**
- **3. Specify the type of debridement and the instruments used (ie. Excisional debridement using a scalpel and forceps).**
- **4. Using modifier 59 on lesions of varying depth if they represent an independent service**

ICD 10 AND ULCER CODING

The L97.xxx group – Non pressure ulcers

- **L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified**
- **Includes:**
  - **chronic ulcer of skin of lower limb NOS**
  - **non-healing ulcer of skin**
  - **non-infected sinus of skin**
  - **trophic ulcer NOS**
  - **tropical ulcer NOS**
  - **ulcer of skin of lower limb NOS**

- **Code first any associated underlying condition, such as:**
  - **any associated gangrene (I96)**
  - **atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-)**
  - **chronic venous hypertension (I87.31-, I87.33-)**
  - **diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)**
  - **postphlebitic syndrome (I87.01-, I87.03-)**
  - **postthrombotic syndrome (I87.01-, I87.03-)**
  - **varicose ulcer (I83.0-, I83.2-)**

- **Excludes2:**
  - **–pressure ulcer (pressure area) (L89.-)**
  - **–skin infections (L00-L08)**
  - **–specific infections classified to A00-B99**

The Fourth Digit

- Relates to the anatomic region
  - .1xx Thigh
  - .2xx Calf
  - .3xx Ankle
  - .4xx Midfoot and heel
  - .5xx Other part of foot

The fifth digit

- Relates to the laterality of the ulcer
  - .x1x Right
  - .x2x Left

The Sixth digit

- **Stage of the ulcer**
  - **.xx1 breakdown of skin**
  - **.xx2 fat exposed**
  - **.xx3 necrosis of muscle**
  - **.xx4 necrosis of bone**
  - **.xx9 unspecified severity**
    - **Remember we never want to use unspecified when using ICD 10**

An Ulcer of the left midfoot with fat exposure is

- **L97.422**

L89.xxx Pressure ulcers

- **Pressure Ulcers have their own L Grouping**
- **As you will see there are similarities to the L97 grou**p

- **Pressure ulcer**
  - **Includes:**
    - **bed sore, decubitus ulcer**
    - **plaster ulcer**
    - **pressure area, pressure sore**

- **Code first**
  - **any associated gangrene (I96)**

- **Excludes2:**
  - **decubitus (trophic)**
  - **ulcer of cervix (uteri) (N86)**
  - **diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)**
  - **non-pressure chronic ulcer of skin (L97.-)**
  - **skin infections (L00-L08)**
  - **varicose ulcer (I83.0, I83.2)**

The fourth digit

- Once again deals with anatomic region
  - .5xx Ankle
  - .6xx Heel
  - .7xx Other site

L89 Fifth Digit

- The fifth digit is still the same
  - .x1x Right
  - .x2x Left

The sixth digit

- Relates to the stage of the ulcer
  - .xx0 Unstagable
  - .xx1 Healing Ulcer Stage 1
  - .xx2 Healing Ulcer Stage 2
  - .xx3 Healing Ulcer Stage 3
  - .xx4 Healing Ulcer Stage 4
  - .xx5 Healing Ulcer Unstagable

Diabetic Ulcers have their own set of E codes

- This is a whole new “ball game”
- All of these are Combination Codes

E10.62 Type 1 diabetes mellitus with skin complications

- **E10.621 Type 1 diabetes mellitus with foot ulcer**

  Use additional code to identify site of ulcer (L97.4-, L97.5-)

E11.62 Type 2 diabetes mellitus with skin complications

- **E11.621 Type 2 diabetes mellitus with foot ulcer**

  Use additional code to identify site of ulcer (L97.4-, L97.5-)

11060/11061 (I&D of abscess)

Common Podiatric Procedures:

Incision and Drainage

10060 10120 10140 10160

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	10 days

Code Description:

10060	I & D of abscess (cutaneous or subcutaneous abscess, cyst, or paronychia) simple or single
10061	I & D abscess (cutaneous or subcutaneous abscess cyst, or paronychia) complicated or multiple
10120	Incision and removal of foreign body, subcutaneous tissue, simple
10121	Incision and removal of foreign body, subcutaneous tissue, complicated
10140	Incision and drainage of hematoma, seroma or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst

Important Notes:

These and similar Minor Procedures (10 day follow-up) usually require adequate Medical Necessity justification. (i.e., C&S, path report, etc.). Inappropriate use of these codes is scrutinized by CMS.

Correct Coding Edits:

These following codes will not be paid if billed with Procedure Code 10060							
11055	11056	11057	11719	11720	11721	11730	11740
11765	20500	64450	69990	97597	97598	97602	97605
97606	G0127						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10061							
10060	11055	11056	11057	11719	11720	11721	11730
11740	11750	11760	11765	20500	29580	29581	64450
69990	97597	97598	G0127				
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10120							
11055	11056	11057	11719	11720	11721	G0127	
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10121							
10120	11720	11721	64450				
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10140							
11055	11056	11057	11719	11720	11721	29580	29581
64450	G0127						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10160							
11055	11056	11057	11719	11720	11721	29580	29581
64450							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

Documentation for I&D Procedures

1. A through description of the abscess
    a. Exact location
    b. Size of the abscess
    c. Signs
    d. Symptoms
2. Culture and Sensitivity
3. Astringent soaks
4. At least a topical antibiotic (after all, this IS an infection)
5. For a complicated I&D, additional documentation is needed:
    a. Local anesthesia
    b. Oral antibiotic
    c. Separate op report
6. The patient needs to be seen 1 time post operatively WITHIN the 10 day global period

11050 series (paring of skin lesions) (corns/calluses)

In general the following CPT codes are paid by Medicare when a patient has a qualifying systemic disease and Class Findings and is usually reimbursable every 61 days per CMS.

***Please check the LCD for Routine Foot Care of your Medicare Administrative Carrier**

- **11055 Paring or cutting of benign hyperkeratotic lesion (eg. corn or callus); single lesion**
- **11056 two to four lesions**
- **11057 more than four lesions**

11050 series (paring of skin lesions) (corns/calluses)

Please check with the respective Medicare Advantage Plans, Medicaid Carriers (HMO, traditional), Commercial Insurance Carriers to confirm whether or not these three codes are covered entities per the policies of the various companies in advance of treatment and billing

11050 series (paring of skin lesions) (corns/calluses)

The most appropriate ICD-10 code to use for these three CPT codes is:

L84 Corns and callosities

Please refer to the Routine Foot Care section earlier in this presentation for billing and coding documentation for 11055, 11056, 11057 and of course the LCD of your respective Medicare Administrative Carrier

Orthotics Codes

- **1. Orthotics are statutorily NOT COVERED by any Medicare Administrative Carrier**
- **2. So why are orthotics targeted by CMS to be audited?**
- **3. Providers have found an inappropriate method to bill for orthotics by bypassing the rules and regulations**
  - **The orthotics are billed to the respective Durable Medical Equipment Carrier (DMERC) inappropriately using the KX modifier**
  - **The KX Modifier: Documentation on File**

    Use this Medicare modifier to indicate that specific documentation is contained in the medical record to justify the billed service. This modifier is used on all line items for claims that are submitted to the DMERC.

Orthotics Codes

- **4. When orthotics are inappropriately billed to the DME Carrier (ie. L3020 KX,LT,RT @ 2 units), the KX modifier allows an automatic bypass and allows payment of this code**
- **5. When an audit occurs, the KX modifier states that the necessary documentation is on file to justify the billed service. Since the service is NOT covered, there is no supporting documentation on file, thus how does one justify the billing for orthotics?**

59 Modifier

"Excerpt from a CMS publication re: Modifier -59"

{Modifier -59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. According to Medicare (CMS) -59 can be used to indicate a DISTINCT secondary procedure or service performed on the same day as another primary procedure or service. If the secondary procedure is performed on a different anatomic site, a separate incision or excision, a separate lesion or a separate injury site, Modifier -59 should be attached to the secondary or lesser service in the code pair (refer to the "National correct Code Edits" Section 3 pages 3:58) This Modifier should only be used if no other modifier, more appropriately, describes the relationships of the 2 or more procedure codes. Modifiers –TA, -T1, -T2, -T3, -T4, -T5, -T6, -T7, -T8, -T9, -LT, -RT, 25, -58, -78, -79 must be used to establish the different anatomic site or incision/lesion; -59 should be used only if these other modifiers are not appropriate.}

NOTE: The Office of Inspector General has found that 40% of the use of -59 does not meet program requirements, resulting in $59 million in improper payments. Be aware!!!!

USES OF THE - 59 MODIFIER

1. used only on a procedure code, never on an E/M code

2. that procedure code was a distinct or separate service from other services performed on the same day

3. it is an anatomical modifier(there is not available an anatomical modifier to show that the procedure was a separate service from other services performed on the same day)

4. it is a multiple procedure modifier

Injection Codes

Trigger Point Injections

20550 20551 20552 20553 20600 20604 20605 20606 20610 20611 20612

Code Quick Reference: The descriptions of CPT Codes 20600, 20605 and 20610 have changed for 2015.

Assistant Surgeon	Not Covered
Follow-up days	0 days

Code Description: CPT Codes 20604, 20606 and 20611 are all new for 2015.

20550	Injection (s); single tendon sheath, or ligament, aponeurosis (e.g., plantar fascia).
20551	Injection(s); single tendon origin/insertion.
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s).
20553	Injection(s); single or multiple trigger point(s), three or more muscles.
20600 20604	Arthrocentesis, aspiration and/or injection; small joint or bursa (toes);without ultrasound guidance With ultrasound guidance
20605 20606	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (ankle);without ultrasound guidance With ultrasound guidance
20610 20611	Arthrocentesis, aspiration and/or injection; major joint or bursa (knee);without ultrasound guidance With ultrasound guidance
20612	Aspiration and/or injection of ganglion cyst(s) any location.

Important Notes:

Correct use of these codes requires that documentation be specific. Multiple trigger point injections noted in your record is not adequate. Specify material, quantity, and location of each injection.

Medical Record Requirements:

Medical Necessity dictates the use of a treatment plan

Several medical carriers require medical records including the following:
History of onset of painful conditions and probably cause
The pain distribution pattern of the trigger point (each trigger point tends to have a distinct pain pattern).
Any restriction of range of motion.
Any focal areas of tenderness.
Any tightness associated with the trigger point.
Ability to reproduce the referred pain pattern when trigger point stimulated.

Billing Notes:

Multiple injections are billed using the -51 modifier, based on the multiple procedure rules.
The injection material can be billed using the appropriate J code.

Some MAC's require the -50 modifier to be used for bilateral injections of the same type. The injection material can be billed using the appropriate J code (bill is submitted to the MAC).

New CPT Codes for Injections Effective January 1, 2015

- **20600 Arthrocentesis, aspiration, and/or injection, small joint or bursa (eg. fingers, toes); without ultrasound guidance**
- **20604 with ultrasound guidance, with permanent recording and reporting**
- **20605 Arthrocentesis, aspiration, and/or injection, intermediate joint or bursa (eg. temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranonbursa); without ultrasound guidance**

New CPT Codes for Injections Effective January 1, 2015

- **20606 with ultrasound guidance, with permanent recording and reporting**
- **20612 Aspiration or injection of ganglion cyst(s) any location**

(to report multiple ganglion cyst aspirations/injections use 20612 and append the 59 modifier)

Diagnostic/Therapeutic Nerve Block

64450

1. It is appropriate to use this code, injection of an anesthetic agent for TWO reasons:
   a. Diagnostic purposes
   b. Therapeutic purposes: control of pain resistant to conventional forms of treatment (i.e., oral medication, physical therapy, immobilization, etc.)
2. It is NEVER appropriate to bill for a nerve block in conjunction with a surgical procedure code. It is ALWAYS included (see the Correct Coding Guide).
3. Medical record documentation MUST clearly establish medical necessity.

64455

❖ Injection(s), anesthetic agent and/or steroid, plantar common digital nerves(s) (e.g. Morton's Neuroma)

QUESTIONS?