Coding For Foot Care Questions Answered!

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Two Different Things!

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- Routine Foot Care
- Debridement of Nails

- Qualifying Diagnosis + Class Findings
- Onychomycosis + Secondary Diagnosis
Questions!

In regards to Nail Debridement, I know the patient needs to have Tinea Unguium and Pain. Does the patient have to also have Marked Limitation of Ambulation also?

Is there a complete program/certification for podiatry for Coding & Billing?
Does the Q modifier only for Medicare INCLUDE Medicare Replacement plans??

What about if they see a PA?

Do we need to use "Q" modifiers and/or "X" with all insurances or just Medicare?

What codes do we use for diagnosis of the toenails for routine foot care qualifying patients if we don't need onychomycosis?
How would you attach modifiers to a patient that had a 11719, 11720, and 11056? Patient qualifies with a Q8

We have a patient whose nails grow incredibly quick. Nearly every nail is thick and he does not meet any criteria so we are unable to get his services covered under the debridement LCD. Is there any way to get the services covered any sooner than our required 61 days?

How do you code/bill for debridement of callosities within the 61 day period? Sometimes those who meet qualification develop the callosities quickly OR will develop a new one but we have been unsuccessful in billing for these additional debridements.

Do you have to get a pathology dx of onychomycosis...or just your clinical dx?
What ICD codes do you use if they have less than 5 mycotic nails and you want to bill 11720 and 11719?

My LCD approves RFC under idiopathic progressive neuropathy (G60.3) but not idiopathic neuropathy (G60.9). I usually use G60.3 since I figure it’s not getting better so it must be progressive. Your thoughts?

How do we code for calluses that are deep-seated, (IPK) when patient is in office for foot care and makes that complaint of pain? Can calluses and IPK’s be treated and charged at the same visit? Which code is used for 17110, treatment of painful IPK?

CPT 17110 - Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

Are you saying "XS"?
X Modifiers – Medicare only?

- XE - Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XP - Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XS - Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XU - Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

I cannot get Humana Med Adv to pay for 11720 or 11721 with a lesion code on the same visit. Any suggestions?

Is it correct that in California DM, PAD and peripheral neuropathy are the only qualifiers for routine foot care?

I have never used G code in 15 years. Now what??
How about all the Medicare advantage plans— bill and code and document as they are Medicare?

What if patient cannot recall exact date last seen? But says about two weeks ago. Can we decide on a date and list that?

Do you have to document Class C Findings / subjective findings every visit?

How do you escape carbon copy notes?
Does q7 apply to both feet if non traumatic amputation is only on one foot?

What diagnostic code would you use for "nondystrophic nail"?

Define nontraumatic amputation

For a first time patient can you charge for an E&M if nails are the only diagnosis?
With the ‘2nd pathway’ of billing debridement of nails (11720 and 11721), if nails are mycotic, no class findings, do they have to treat the nail fungus (topical, etc.) for continued coverage? If they just opt to not treat the fungus, can they still be covered, as long as there is still pain?

What happens when patient has painful corn? No class findings?

How does Medicare define "redness" in the list of B class findings?

Will 11055 ever be covered without class findings?
What is the correct way to code for shaving of a porokeratosis? I recently had this conversation with colleagues as I had just done a 11055/11056/11057 but I have colleagues that have said they do 11305/11306/11307 and another that does 17110.

Should Q modifiers only be placed on Medicare patients or added to all patients if they have appropriate findings?

Can you use pain on foot instead of toes for debridement or a code that does not give a specific side but rather a general pain in toes?

If someone has diabetes with neuropathy, but no PVD, do they qualify for at risk nail care?
An HPK has a hemorrhagic base sub-5th.
Painful without qualifying diagnoses.
We bill 97957 for superficial ulceration debridement.

Any concerns?

Which meds do Medicare consider anti-coagulants?

How do you code for MD last visit?

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