10 Reasons for Medicare and Insurance Audits & Tips on How to Survive Them

May 4, 2022

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Michael G. Warshaw, DPM has no actual or potential conflict of interest in relation to this program.

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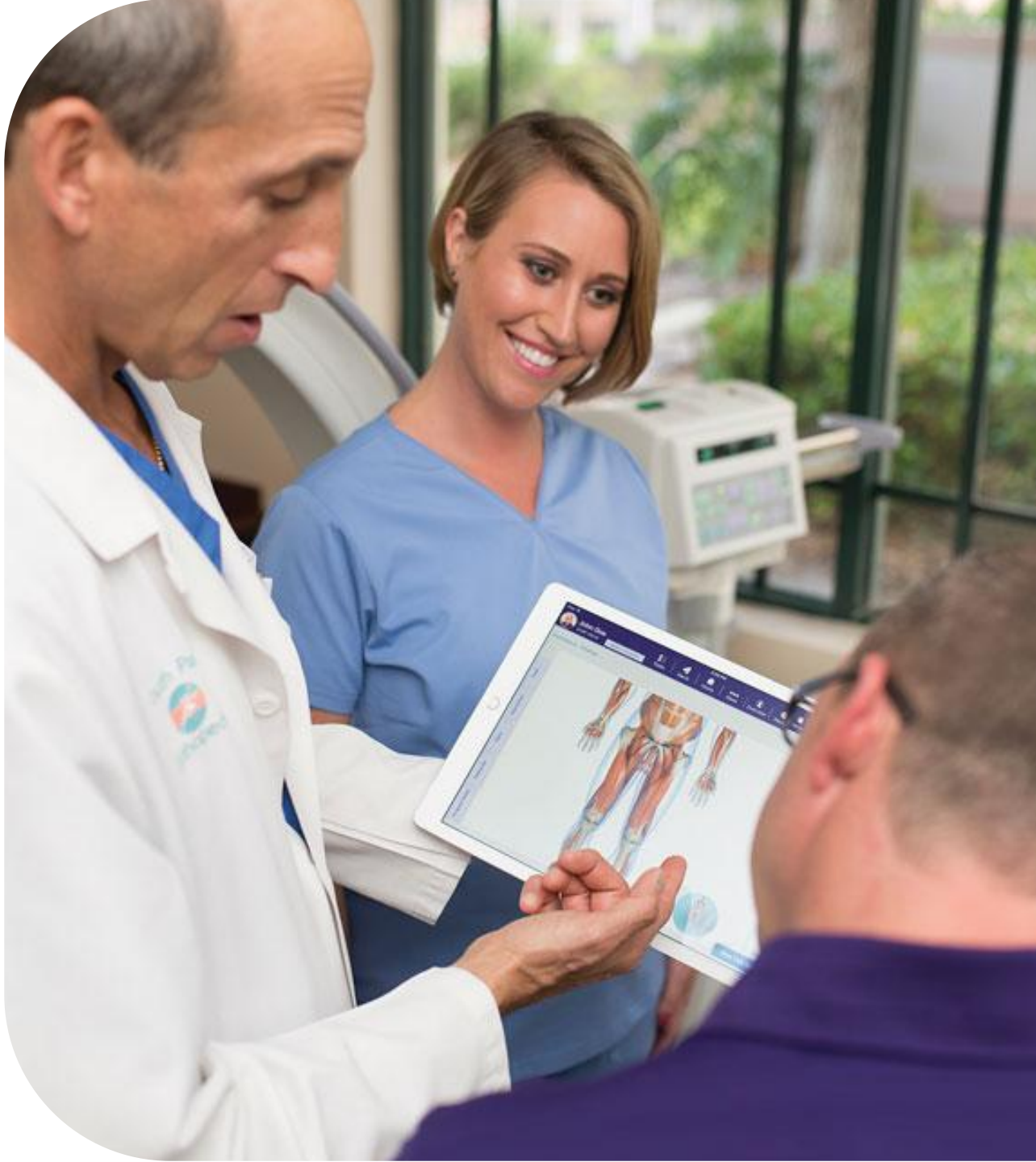
KEY FACT:
Podiatry has been, and continues to be, a highly audited medical specialty



Most Commonly Audited Codes in Podiatry

- The Inappropriate Use of the 25 Modifier
- The inappropriate Use of the 59 Modifier
- 11720/11721 (nail debridement)
- 11730 (nail avulsion)
- Wound Care Codes
- 10060/10061 (I&D of abscess)
- 11050 series (paring of skin lesions) (corns/calluses)
- Orthotics Codes
- Injection codes (Morton’s neuroma, plantar fasciitis)
- 11305 Series of Codes

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
- 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

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

The 25 modifier is only used on an E/M service

An INITIAL E/M service CAN be billed when performed on the SAME date of service as a minor surgical procedure

The diagnosis code for the INITIAL E/M service and the diagnosis code for the minor surgical procedure CAN be the SAME

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

E/M Services

There can be NO CORRELATION between the E/M service and the minor surgical procedure.

If an ESTABLISHED patient is seen for a NEW problem and a minor surgical procedure is performed on the SAME date of service, then BOTH the established patient E/M service code AND the minor surgical procedure code be billed for. The diagnosis codes for the E/M service and surgical procedure can be the SAME.

The entire scenario needs to be completely documented in the medical record.

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59 Modifier

- Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances.
- Documentation must support a different session, different surgery or procedure, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

59 Modifier con’t

- However, when another established modifier is appropriate it should be used rather than modifier 59. Thus, the physician or his/her designated appointee, the biller or the coder need to perform a modifier search to determine whether or not there is another modifier that should be used in lieu of the 59 modifier. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used. In reality, modifier 59 is not the modifier of first choice, rather it is the modifier of last resort.

59 Modifier con’t

- How does CMS know whether or not the 59 modifier is being used correctly? They have software that determines this fact. There is a “Four Bullet Punch List” that determines whether or not the 59 modifier was used correctly. Anytime the use of the 59 modifier is contemplated, one must apply the CPT code in question to each of the “Four Bullets.” If it passes four out of four, it is appropriate to append the 59 modifier to that CPT code.

THE “FOUR BULLET PUNCH LIST” FOR THE CORRECT USE OF THE 59 MODIFIER:

- 1. The 59 modifier is ONLY used on a procedure code, NEVER on an E/M code.
- 2. The procedure code in question is a DISTINCT or SEPARATE service from the other services performed on the SAME DAY.
- 3. The 59 modifier serves as an anatomical modifier. Why?
    - Because there is not available a true anatomical modifier to show the carrier that the procedure code in question is a separate service from the other services performed on the same day.
- 4. The 59 modifier is a multiple procedure modifier.
    - There have to be at least 2 procedures performed.
    - The 59 modifier is appended to the second procedure based upon how they are listed in the CCI edits.
    - Don’t “hedge your bets” by placing the 59 modifier on All of the CPT codes that you are billing that day. This is highly inappropriate.

11720/11721 (Nail Debridement)

Ongoing Confusion Over Qualified Routine Foot Care

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

Routine Foot Care

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 the 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 Foot 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. Confirm with your MAC's LCD for RFC.

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 **Active Care Requirement.** 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.

"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. Neurological and vascular complications of diabetes are the primary "asterisk" systemic diseases.

Include the following in your medical record: Please confirm with your MAC's LCD for RFC.

- 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 form: Please confirm with your MAC's LCD for RFC.

- 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-10 code) in Field 21, line 1 or line 2 (Primary Diagnosis or perhaps Secondary Diagnosis)
- *The systemic disease (ICD-10 code) of the treating MD or DO in Field 21, line 2 or line 1 (Secondary Diagnosis or perhaps Primary) 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 designation has different requirements for record keeping and billing. The systemic disease diagnosis and subsequent treatment of that systemic disease can be made by an MD or DO as appropriate. 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. The date last seen is not a requirement for the non-asterisk systemic diseases. Please confirm by reading your MAC's LCD for RFC.

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 form:

- 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
- *Podiatric diagnosis (ICD-10 code) in Field 21, line 1 or line 2 (Primary Diagnosis or perhaps Secondary)
- *The systemic disease (ICD-10 code) in Field 21, line 2 or line 1 (Secondary Diagnosis or perhaps Primary)

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 "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 CMS-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

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: This must be documented for each of the affected toenails.

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

How To Bill Medicare For Mycotic Nail Services

If the patient's condition meets the published, very specific, limitations for payment for Fungus Nail services, Medicare can be billed by using either 11720 or 11721. The 11720 code is used for debridement of 1, 2, 3, 4, or 5 nails by any method. The 11721 code is used for debridement of 6 or more nails by any method. These codes are considered appropriate only for the surgical thinning of markedly thickened nails that require thinning to a more normal thickness.

INCLUDE THE FOLLOWING ON THE BILLING CLAIM FORM:

The Primary Mycotic Diagnosis (ICD-10 code) in Block 21 line 1
The Secondary Condition Diagnosis (ICD-10 code) in Block 21 line2
Use either 11720 or 11721 in Block 24d

PRIMARY DIAGNOSIS:

B35.1	Dermatophytosis of nail

SECONDARY DIAGNOSIS:

R26.2	Difficulty in walking, not elsewhere classified
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
L03.031	Cellulitis of right toe(s)
L03.032	Cellulitis of left toe(s)

*L03.031 and L03.032 are the crosswalks for paronychia

Partial or Total Nail Avulsions- CPT Code 11730

- 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)

Partial or Total Nail Avulsions

- Post-operative instructions and follow-up care should be documented
- If medial and lateral border are 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 20 SQUARE CENTIMETERS
- *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

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 based upon the deepest level of necrotic tissue that is excisionally debrided from within the wound or ulcer. 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)

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

Note 2: Consider

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

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.

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

GRADE OF THE ULCER:

----- .XX1	BREAKDOWN OF SKIN
-----.XX2	WITH FAT LAYER EXPOSED
-----.XX3	WITH NECROSIS OF MUSCLE
-----.XX4	WITH NECROSIS OF BONE
-----.XX5	WITH MUSCLE INVOLVEMENT WITHOUT EVIDENCE OF NECROSIS
-----.XX6	WITH BONE INVOLVEMENT WITHOUT EVIDENCE OF NECROSIS
-----.XX8	WITH OTHER SPECIFIED SEVERITY
-----.XX9	WITH UNSPECIFIED SEVERITY

AN ULCER OF THE LEFT MIDFOOT WITH FAT EXPOSURE IS:

L97.422

Pressure Ulcer Staging

Effective January 1, 2009, the term “decubitus ulcer” was changed to “pressure ulcer.” A six part staging system for pressure ulcers was put into effect on January 1, 2009, as well. This is what ICD-10 has incorporated to base the series of L89- upon. Classification systems, whether Wagner, University of Texas, etc. for ulcer grading do not apply to pressure ulcers.

Unspecified Stage

Stage 1

- *An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues*

Stage 2

- *Partial thickness skin loss involving epidermis, dermis, or both.*
- *The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater*
- *It is inappropriate to bill for the debridement of a Stage I or a Stage II Pressure ulcer*

Stage 3

- *Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.*

Stage IV

- *Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.*

Unstageable

- *Eschar – Thick dry black necrotic tissue*

L89.xxx Pressure ulcers

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

- 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-)

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**

It is inappropriate to bill for the trimming of a corn or a callus if it is located distal to the DIPJ or on the skin overlying the DIPJ of a lesser toe or distal to the IPJ on a great toe and the same toe had a toenail debrided or trimmed.

11050 series (paring of skin lesions)

(Corns / Calluses con’t)

The most appropriate/common 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, either inadvertently, by their billers/billing company, or by design 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 con't

- 4. When orthotics are inappropriately billed to the DME Carrier (ie. L3020 KX,RT; L3020 KX, LT), 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?

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, olecranon bursa); without ultrasound guidance
- 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)

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1130 5 Series of Codes Shaving of Epidermal or Dermal Lesions

Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require closure

This series of CPT codes are biopsy codes. A specimen needs to be submitted for pathological analysis.

The trimming or debriding of a corn, callus or hyperkeratotic tissue does not qualify for the use of this CPT code set. The use of “at risk” foot care codes 11055, 11056, 11057 would be appropriate. If the patient does not qualify for “at risk” foot care,” this is statutorily not covered.

Furthermore, with the introduction of the new biopsy CPT codes for 2019 (ie. 11102: Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion), are the 11305 series of codes really necessary any longer?

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“Healthcare Inequities Impacting Women & Children”

Tuesday, May 24, 2022, 1:00 PM EST

With Dr. Hung Ecklund and Dr. Julie Servoss

Did you know that while maternal mortality statistics among peer nations have generally improved over the past 20 years, rates in the US have worsened? In observance of Women’s Health Month in May, join us for this important webinar to discuss the increasing morbidity and mortality rates for women and children in our country. We’ll also explore how racial and ethnic disparities add complexity to this issue and explore ways to address these inequities.

To register, click the link in the chat box.

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