2023 Medicare Part B Update – Annual Meeting of the New York Podiatric Medical Association

January 19, 2023

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NGS MU NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

NYSPMA-01192023

Today's Presenters

- Provider Outreach and Education
  - Jim Bavoso

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To help podiatrists and their billing staff learn how to avoid requesting an appeal by providing education on how important it is to apply the LCD for Routine Foot Care and Debridement of Nails (L33636) to routine foot care claim submissions.

Agenda

- Status COVID-19 Public Health Emergency
- Medicare Physician Fee Schedule – 2023 Deductibles and Coinsurance
- 2022 E/M Changes
- Telehealth
- Medical Review – Targeted Probe & Educate
- Your questions

National Government Services (NGS) as the Medicare Administrative Contractor (MAC)

- The Information presented here represents NGS as the MAC for J6 and JK.
- J6 - states of Illinois, Minnesota and Wisconsin
- JK - states of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont
- If you practice in a state other than these, please contact your Local MAC for specific guidance.

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Staying Informed
COVID-19 Public Health Emergency

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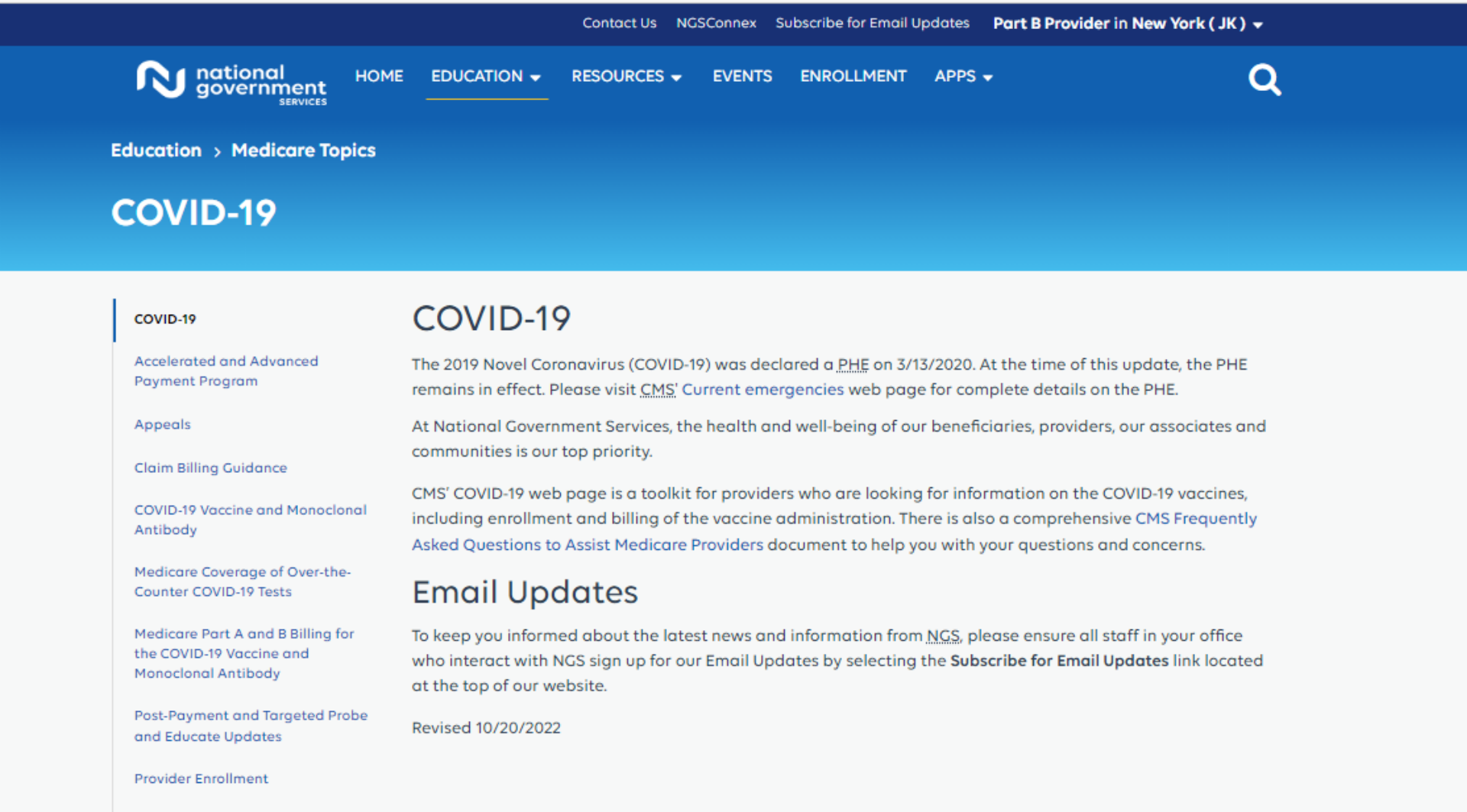
Renewal of the Public Health Emergency

- January 11, 2023, the Public Health Emergency (PHE) has been extended an additional 90 Days
- [COVID-19: Renewal of Determination that a Public Health Emergency Exists (hhs.gov)]

Special Disclaimer and Suggested Actions

- During COVID-19 PHE, information and instructions may change and will turn to prior instructions following PHE
  - PHE set to expire on 4/11/2023
  - U.S. Department of Health & Human Services Public Health Emergency
- Vital to ensure providers receive latest information
- Take steps to ensure you have access to the latest updates by signing up for email communications
  - CMS Email Updates and
  - National Government Services Email Updates
- Routinely check
  - CMS Current Emergencies web page and
  - NGS COVID-19 Medicare Topics web page

NGS COVID-19 Homepage



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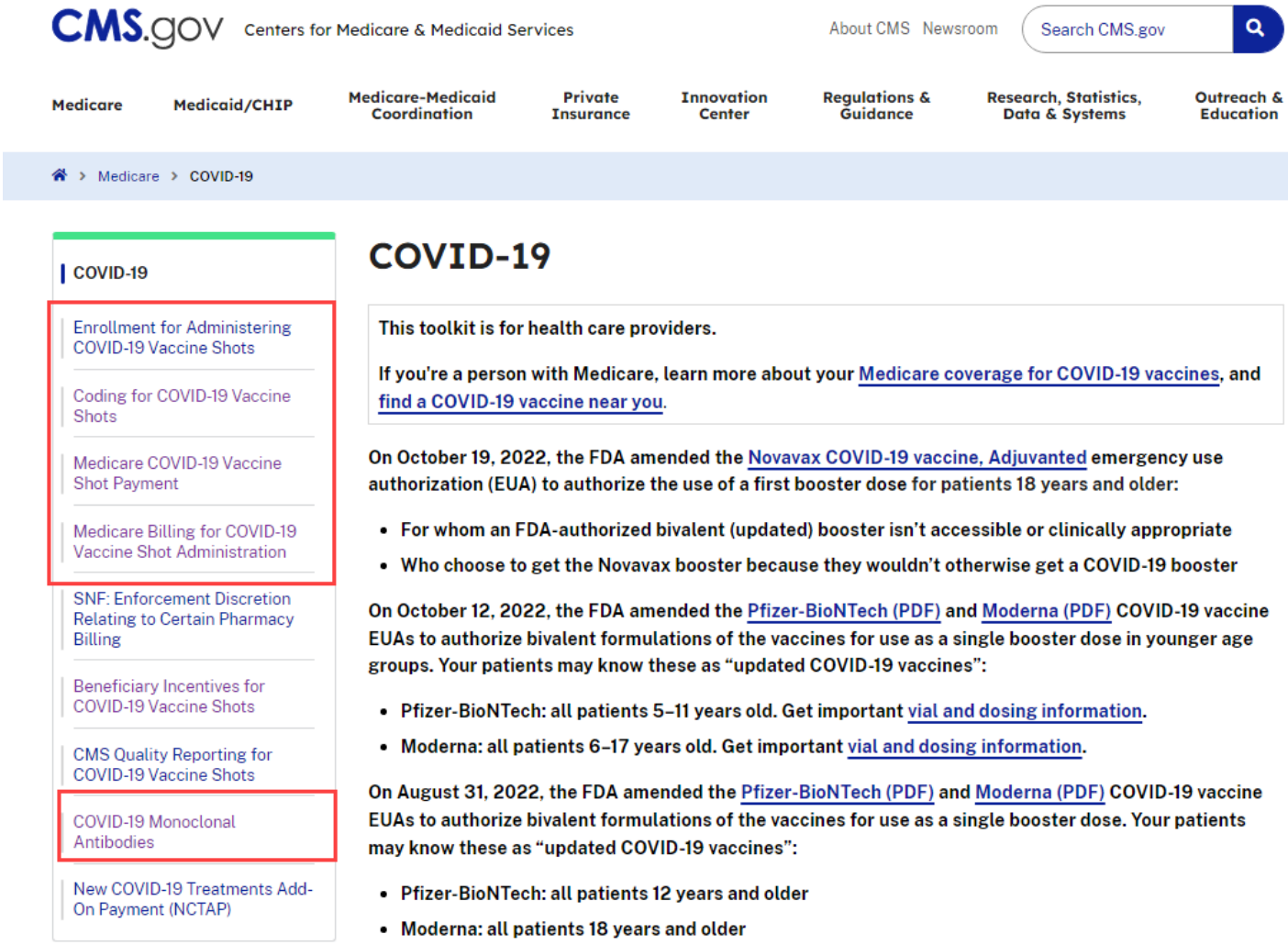
COVID-19 Homepage



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Medicare Part B Premium and Deductibles

2023 Medicare Premium and Deductibles

2023 Premium and Deductibles	Amounts
Monthly Part B Premium *Individual income above $97,000 up to $123,000 pay higher part B Premium	$164.90 (-$5.20) *$230.80
Part B Deductible	$226 (-$7)
Part B Coinsurance	20%
Mental Health Services	80%
Part A IH Deductible (first 60 days)	$1,600 (+$44)
Days 61st -90th Days	$400 (+$11)
Lifetime reserve day	$800 (+$22)
Skilled Nursing Facilities (21st-100th days)	$200.00(+$5.50)

Medicare Physician Fee Schedule

Medicare Physician Fee Schedule

- The CY 2023 MPFS is now available
- View the new fees using the Fee Schedule Lookup tool on NGSMedicare.com

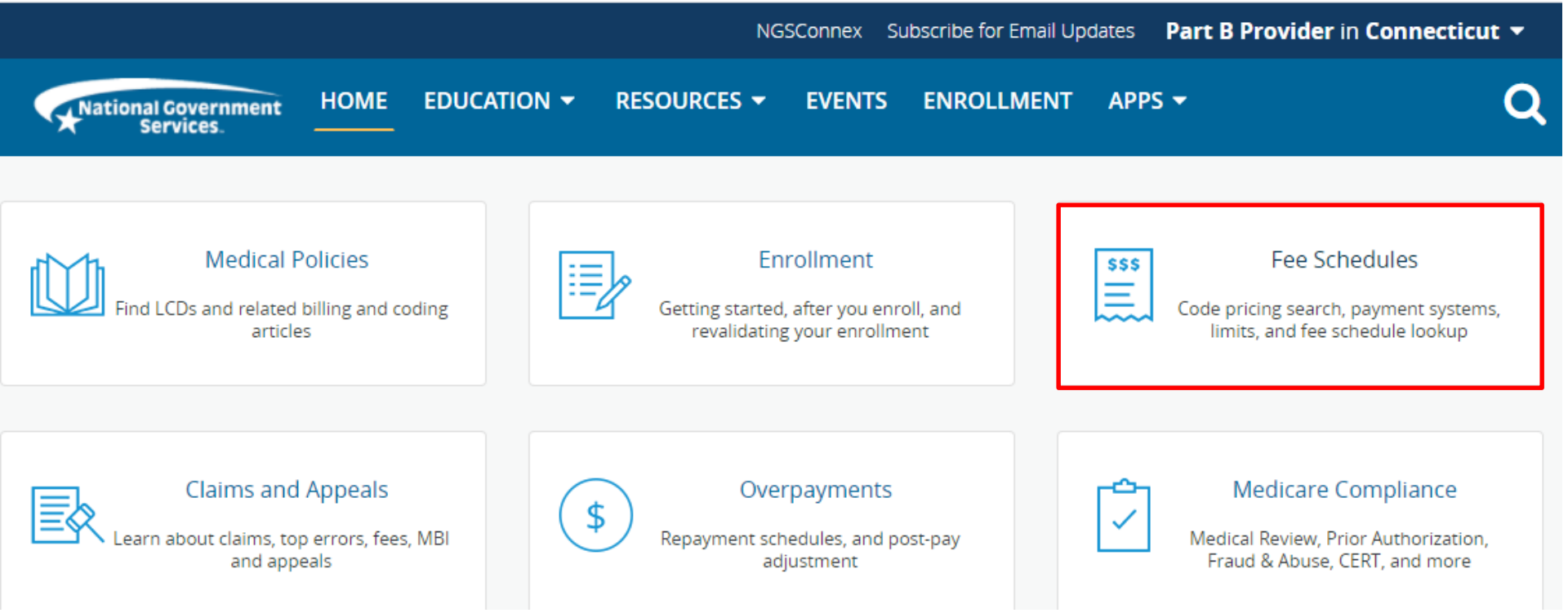
2023 Physician Fee Schedule (PFS) Ratesetting and Conversion Factor

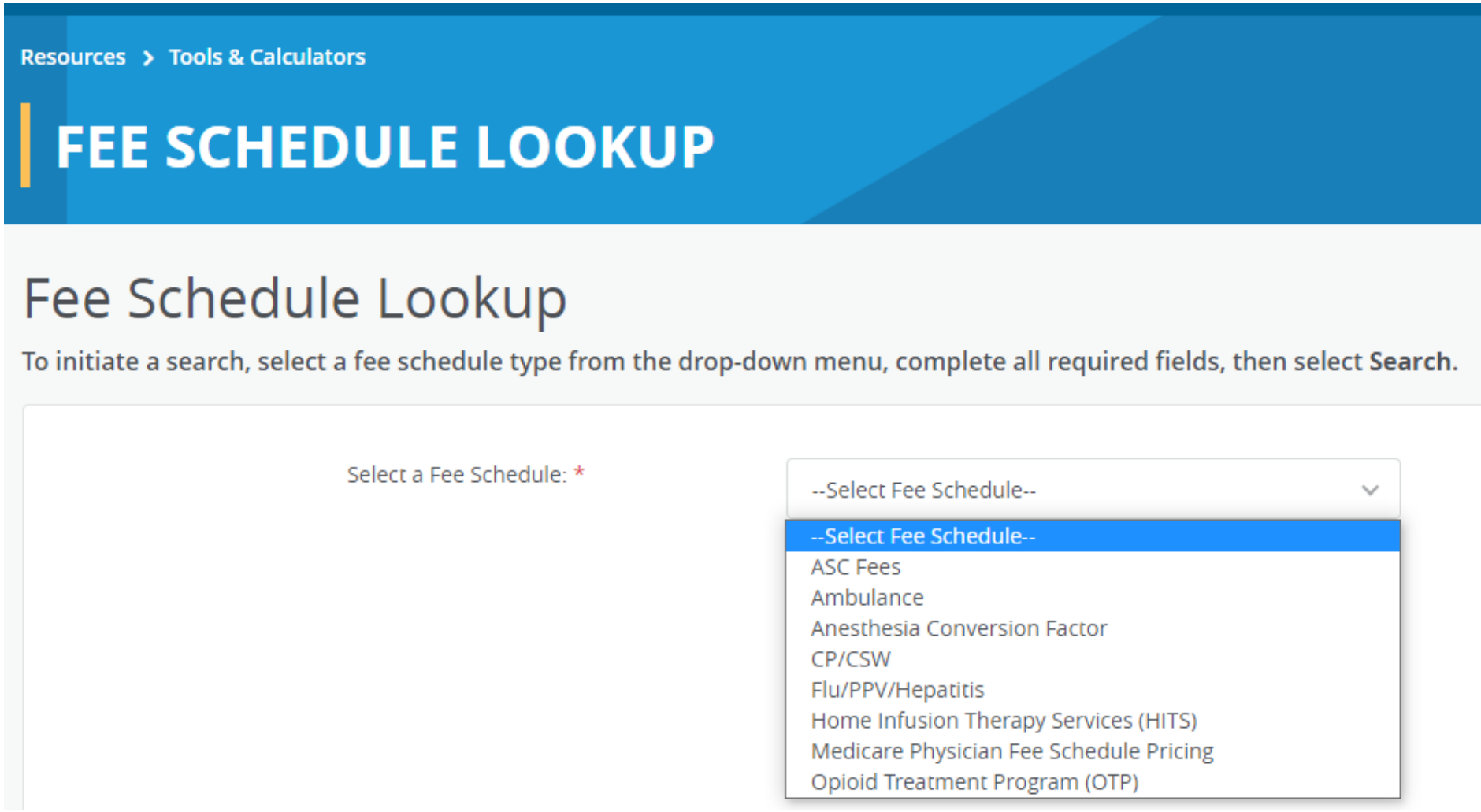
- The Consolidated Appropriations Act, 2023
- Revised 2023 PFS conversion factor is $33.8872
  - A decrease of $0.719 from the 2022 PFS conversion factor of $34.6062
- Expiration of the three percent supplemental increase to the PFS payments for CY 2022

Updated Medicare Economic Index (MEI) for 2023

- CY 2023 MEI update
  - 3.8 percent
  - Rebased and revised MEI weights were not used in the CY 2023 PFS ratesetting
  - Medicare economic index (MEI) means **a measure of the inflation faced by physicians with respect to their practice costs and wage levels as calculated by CMS.**

Fee Schedules




Resources > Tools & Calculators
FEE SCHEDULE LOOKUP
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
Select a Fee Schedule: *
--Select Fee Schedule--
--Select Fee Schedule--
ASC Fees
Ambulance
Anesthesia Conversion Factor
CP/CSW
Flu/PPV/Hepatitis
Home Infusion Therapy Services (HITS)
Medicare Physician Fee Schedule Pricing
Opioid Treatment Program (OTP)

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Select a Fee Schedule: * Medicare Physician Fee Schedule Pricing

Result Type: * Full Fee Schedule / Specific To Fee Code

Date of Service: * 01/02/2023

Procedure Code: * 99213

Region: * Connecticut

Search

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	94.44	89.72	103.18	67.84	64.45	74.12

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99213	01/01/2023	13102	00	Office o/p est low 20-29 min

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	96.80	91.96	105.75	69.54	66.06	75.97

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	33.8872	1.0000	1.30	0.55	1.28

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.10	1.030	1.102	1.070	43.47	

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
11719	01/01/2023	13102	00	Trim nail(s) any number

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	15.26	14.50	16.68	7.79	7.40	8.51

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
R	33.8872	1.0000	0.17	0.04	0.24

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.01	1.030	1.102	1.070	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
000	1	0	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	0	1	0	0

Fee Schedules

Fee Schedule Assistance

The fee schedule assistance page provides access to information about fee schedule definitions and acronyms.

Radiopharmaceutical Reimbursement

The Radiopharmaceutical Reimbursement page provides detailed information on claim submission and reimbursement allowances for radiopharmaceuticals.

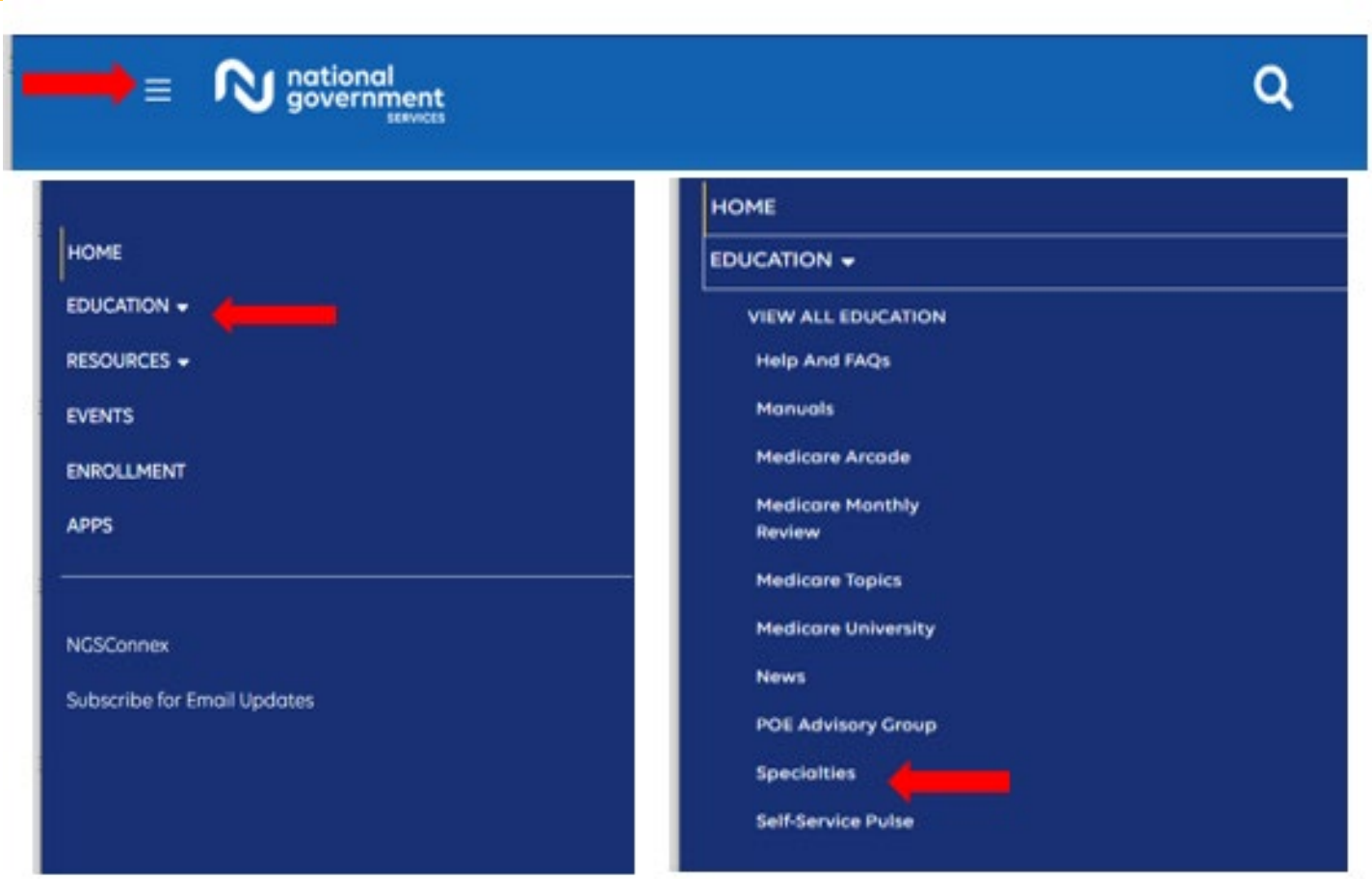
National Fee Schedules

Access the CMS website to view and download the following **national fee schedules**:

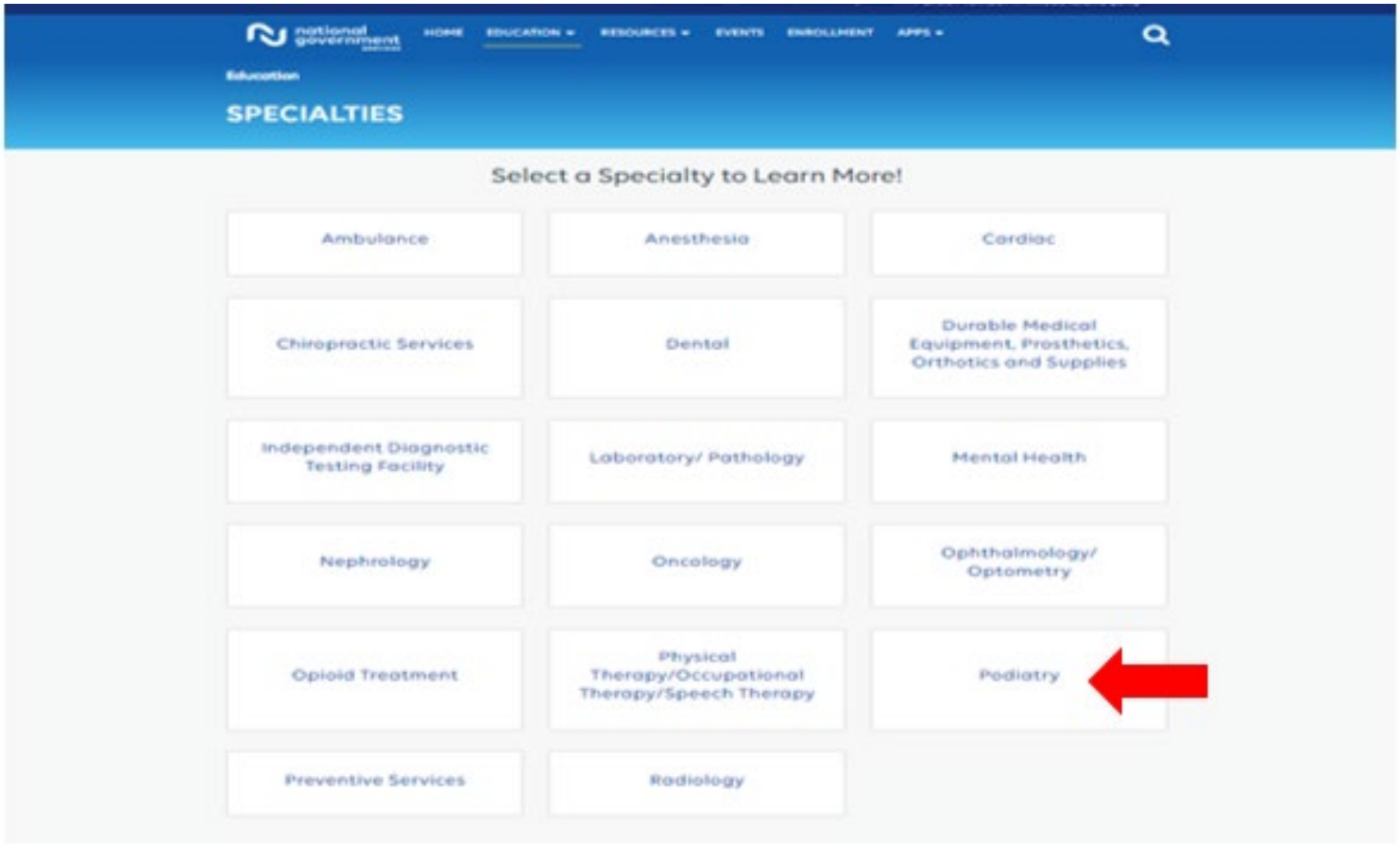
- Ambulance Fee Schedule
- Ambulatory Surgical Center (ASC) Payment
- Clinical Laboratory Fee Schedule
- COVID-19: CMS Allowing Audio-Only Calls for OTP Therapy, Counseling, and Periodic Assessments
- Medicare Part B Drug Average Sales Price
- DMEPOS Fee Schedule
- Vaccines and Administration Pricing
- Home Infusion Therapy (HIT) Fees

Podiatry Billing Guide on www.NGSMedicare.com

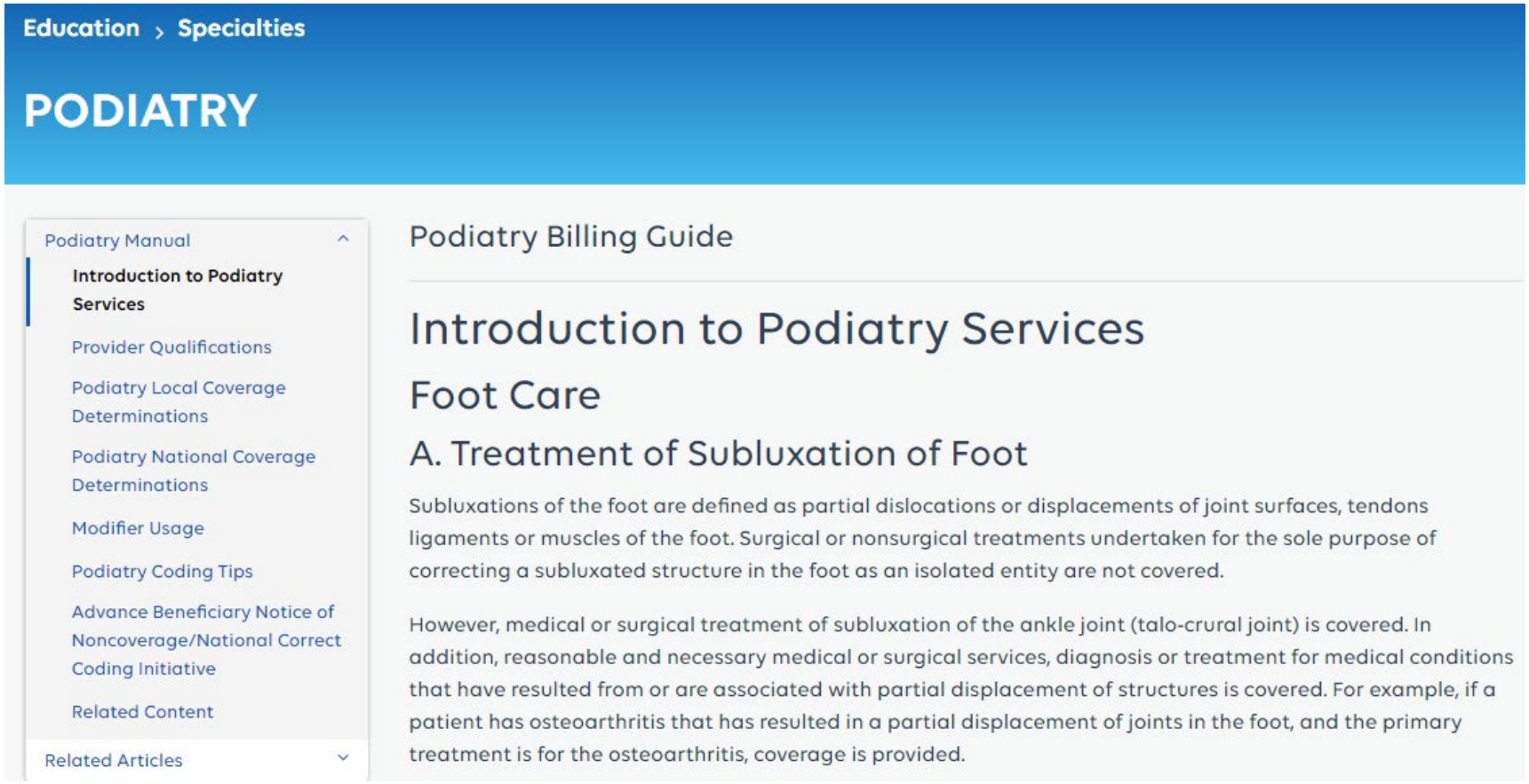
Podiatry Billing Guide



Podiatry Billing Guide

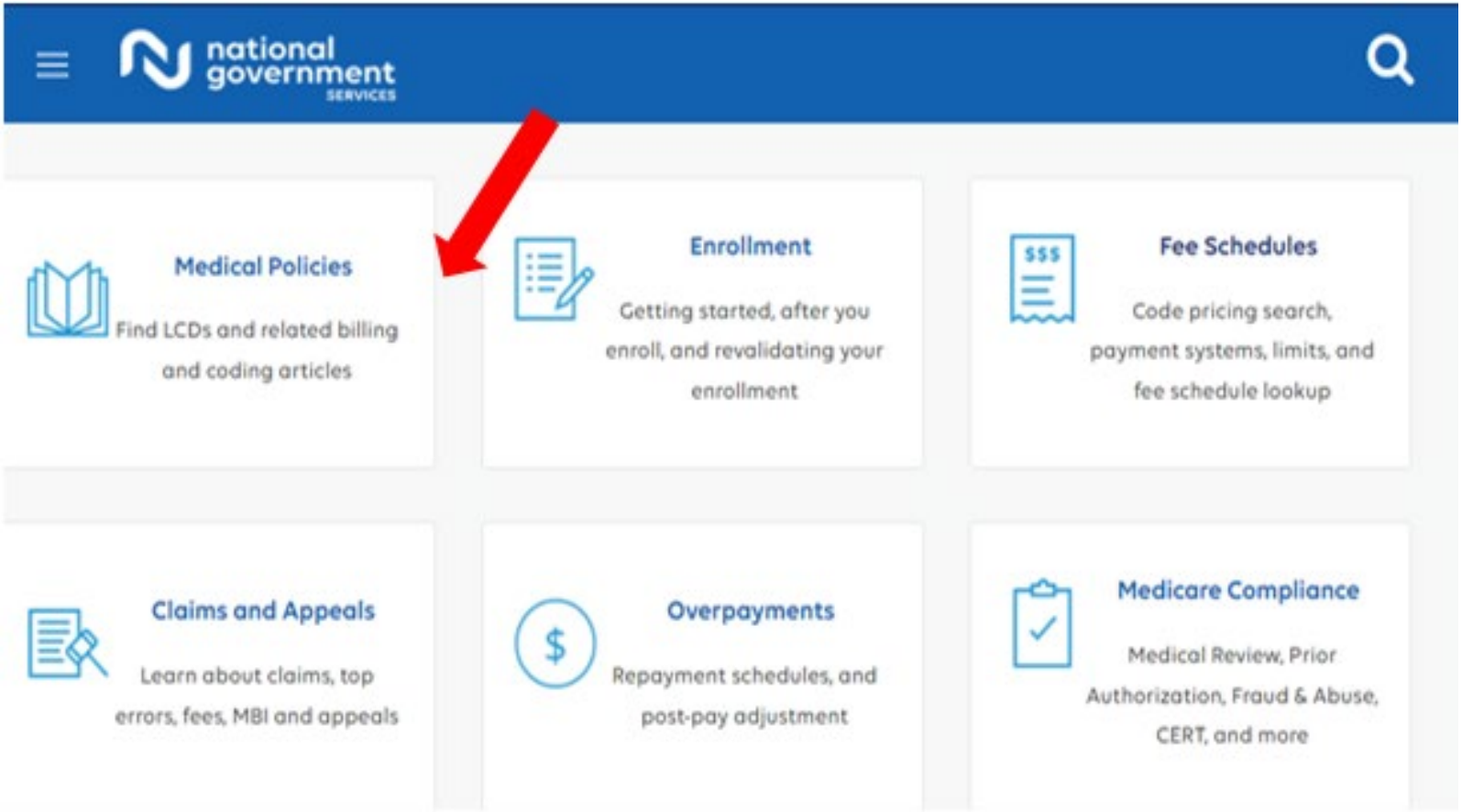


Podiatry Billing Guide



LCD for Routine Foot Care and Debridement of Nails (L33636) & Related Local Coverage Article (A57759)

Medical Policies



Medical Policies - LCDs

Medical Policies - LCDs

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below.

Please note: There are many procedures for which NGS does not have an LCD/Billing and Coding Article. If your search does not return any coverage documents, then NGS does not have a local coverage statement for that procedure.

For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

Routine Foot Care and Debridement of Nails *Related terms: feet, toes, toenails, corns, calluses, trimming of nails, systemic disease*	L33636	A57759	11055, 11056, 11057, 11719, 11720, 11721, G0127

Services Considered to be Components of Routine Foot Care

- Routine foot care generally not covered
  - Cutting or removal of corns and calluses
  - Clipping, trimming, or debridement of nails, including debridement of mycotic nails
  - Shaving, paring, cutting or removal of keratoma, tyloma, and heloma
  - Nondefinitive simple, palliative treatments

Services Considered to be Components of Routine Foot Care

- Other hygienic and preventive maintenance care in the realm of self care
  - Cleaning and soaking the feet
  - Use of skin creams to maintain skin tone of both ambulatory and bedridden patients
  - Any services performed in the absence of localized illness, injury or symptoms involving the foot

Billing CPT/HCPCS Codes

Code	Description
11055	Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); single lesion
11056	Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); 2 to 4 lesions
11057	Paring or cutting of benign hyperkeratotic lesion (EG, corn or callus); More than 4 lesions
11719	Trimming of nondystrophic nails, any number
11720	Debridement of nails(s) by any method(s); 1 to 5
11721	Debridement of nails(s) by any method(s); 6 or more
G0127	Trimming of dystrophic nails, any number

Medical Record & Claim Documentation

Podiatry Claim Coding Tips

- **CPT Coding**: Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127 should be billed with a unit of "1" regardless of the number of lesions or nails treated.
- **Modifiers:** One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127 and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, to indicate the class findings and site:
  - Modifier Q7: One (1) Class A finding
  - Modifier Q8: Two (2) Class B findings
  - Modifier Q9: One (1) Class B finding and two (2) Class C findings
- Note: If the patient has evidence of neuropathy, but no vascular impairment, the use of class findings modifiers is not necessary.

Podiatry Claim Coding Tips

- **Date Last Seen by Attending Physician**
  - ICD-10-CM codes which fall under the active care requirement.
- The approximate date when the beneficiary was last seen by the M.D. or D.O. who diagnosed the complicating condition (attending physician) must be reported in an eight-digit (MM/DD/YYYY) format in Item 19 of the CMS-1500 claim form or the electronic equivalent.
- **Name and NPI of the Attending Physician**
- The NPI of the attending physician must be reported in Item 19 of the CMS-1500 claim form or electronic equivalent.
- Routine foot care procedures are reimbursable only if the patient is under the active care of an M.D. or D.O. for the treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type service.

Podiatry Claim Coding Tips
Modifier Usage

- **25** – Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service
- **24** – Unrelated E/M Service by the Same Physician During a Postoperative Period
- **57** - Decision for Major Surgery
- **59** - Distinct Procedural Service Note: Modifier 59 should not be appended to an E/M service performed on the same date, see modifier 25

Podiatry and Routine Foot Care Documentation Requirements

It is expected that patient's medical records reflect the need for care/services provided. The listing of records is not all inclusive. Providers must ensure all necessary records are submitted to support services rendered. They may include:

- Operative / procedure report
- Practitioner, nurse, and ancillary progress notes

Podiatry and Routine Foot Care Documentation Requirements (continued)

- Documentation to support a systemic condition, neuropathy, vascular impairment, onychogryphosis and/or onychauxis
- Evidence to support active care of a qualifying systemic condition within 6-months of rendering foot care services
- Evidence to support the beneficiary is at significant risk if the service is rendered by anyone other than a DPM, MD, DO, or NPP

Podiatry and Routine Foot Care Documentation Requirements (continued)

- Clinical evidence of 1) mycotic nails, & 2) marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate
- Evaluation of foot structure, vascular and skin integrity
- Debridement of nails with E&M•

Podiatry and Routine Foot Care Documentation Requirements (continued)

- Documentation supporting the diagnosis code(s) required for the item(s) billed
- Beneficiary identification, date of service, and provider of the service should be clearly identified on each page of the submitted documentation
- Documentation to support National Coverage Determination (NCD), Local Coverage Determination (LCD) and/or Policy Article

Podiatry and Routine Foot Care Documentation Requirements (continued)

- Any additional documentation to support the reasonable necessity of the service(s) performed
- Advance Beneficiary Notice
- Signature log or signature attestation for any missing or illegible signatures within the medical record (all personnel providing services)

Podiatry and Routine Foot Care Documentation Requirements (continued)

- Signature attestation and credentials of all personnel providing services
- If an electronic health record is utilized, include your facility's process of how the electronic signature is created. Include an example of how the electronic signature displays once signed by the physician

Billing and Coding: Routine Foot Care and Debridement of Nails

A57759

Expand All | Collapse All

day as a routine foot care service is not eligible for reimbursement unless the E&M service is a significant separately identifiable service, indicated by the use of modifier 25, and documented by medical records.

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within the LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Documentation supporting the medical necessity, such as physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement must be maintained in the patient record.

The clinical documentation must clearly show that the patient's condition warrants a provider rendering these services in accordance with the above instruction, and failure to provide such professional services would be hazardous to the beneficiary due to their underlying medical condition(s). **The billed diagnoses should be supported with clinical findings**. Failure to properly document the reasoning for the care rendered may result in denial of the claim.

There should be documentation of co-existing systemic illness. The physical examination and findings must be precise and specific, with documentation of the location, appearance, characteristics and symptoms of the nails and/or lesion(s). The procedure note must describe what, how and where the procedures were performed and correlate these treatments to the lesions documented on the physical examination. The procedure note may reference the physical examination when describing the treatment(s) given during the procedure (e.g., *left great toe, or right foot, 4th digit.*)

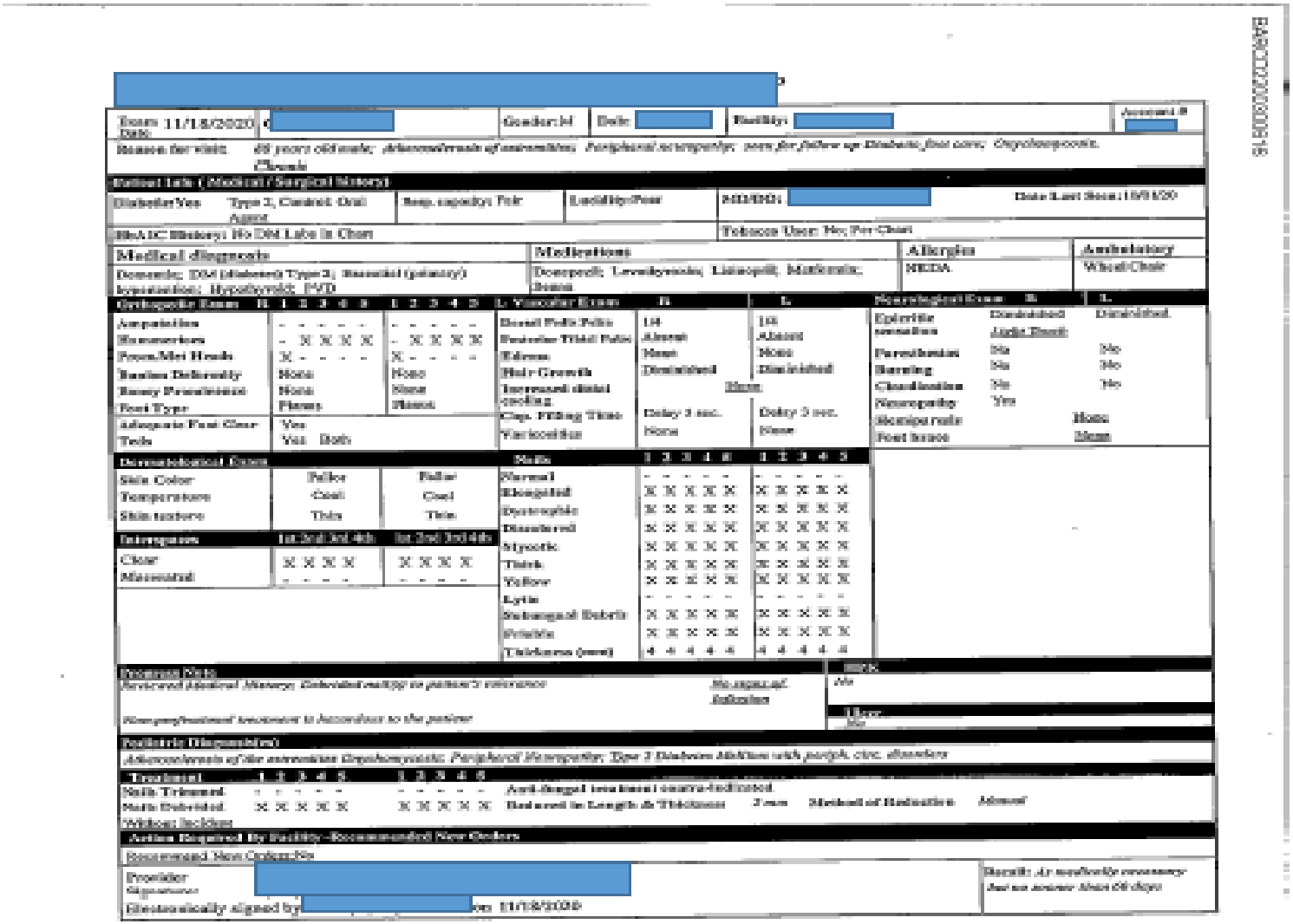
There must be adequate medical documentation to demonstrate the need for routine foot care services as outlined in this determination. This documentation may be office records, physician notes or diagnoses characterizing the patient's physical status as being of such severity to meet the criteria for exceptions to the Medicare routine foot care exclusion.

Routine identification of fungi in the toenail either by culture **or similarly by either nucleic acid probes or amplified probe technique** only is medically indicated only when necessary to differentiate fungal disease from psoriatic nail, or when definitive treatment for prolonged oral antifungal therapy has been planned and there must be adequate documentation in the file. If cultures or nucleic acid probes or amplified probe techniques are performed and billed, documentation of cultures or nucleic acid probes or amplified probe techniques and the need for prolonged oral antifungal therapy must be in the patient record and available to Medicare upon request.

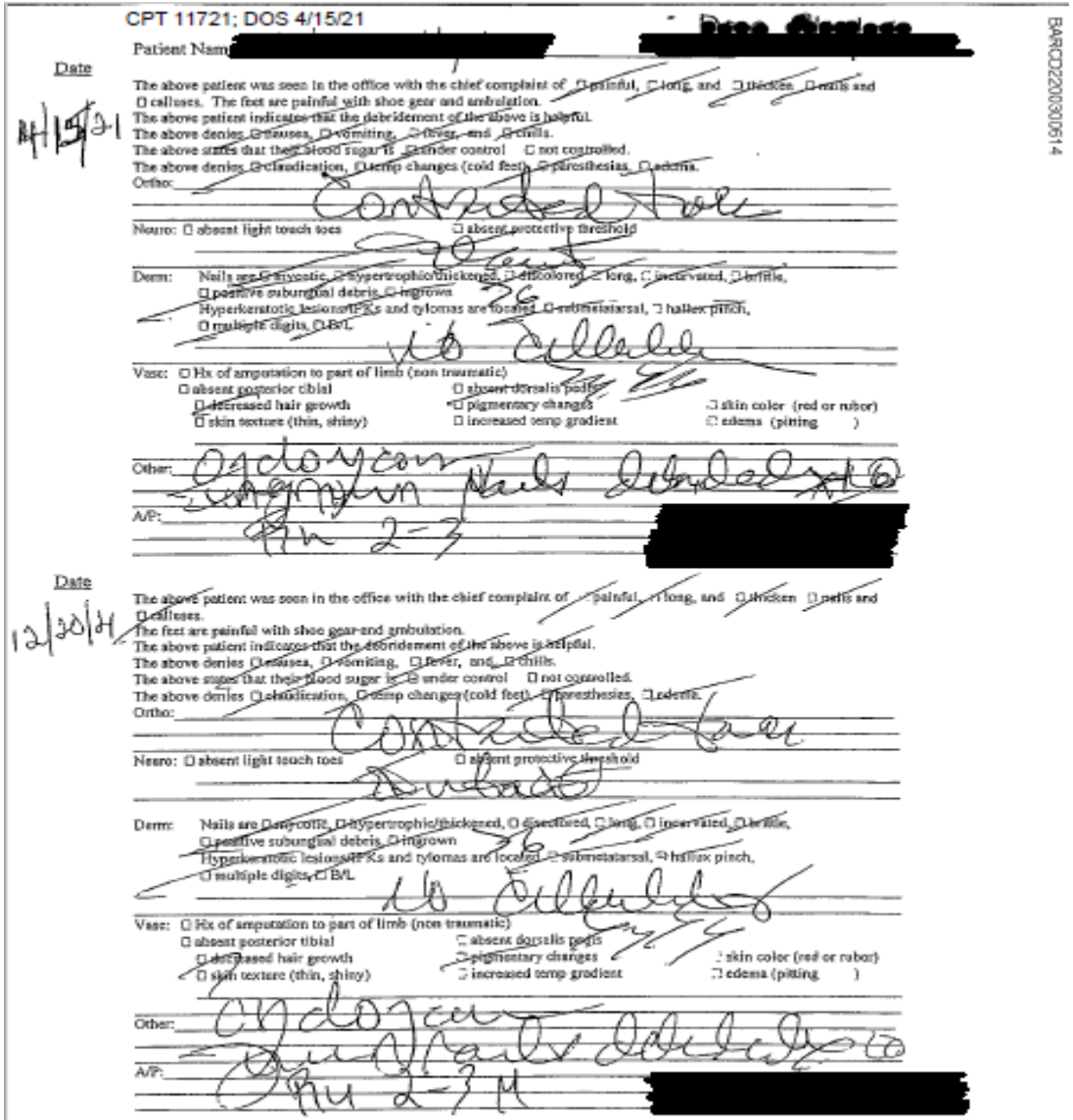
Sample Documentation

Good documentation Code 11721

CPT 11721; DOS 11/18/20



Bad documentation Code 11721



CPT 11721; DOS 4/15/21

Patient Nam[redacted]

BARCD220030614

Date

4/15/21

The above patient was seen in the office with the chief complaint of ☐ painful, ☐ long, and ☐ thicken ☐ nails and ☐ calluses. The feet are painful with shoe gear and ambulation.
The above patient indicates that the debridement of the above is helpful.
The above denies ☐ nausea, ☐ vomiting, ☐ fever, and ☐ chills.
The above states that their blood sugar is ☐ under control ☐ not controlled.
The above denies ☐ claudication, ☐ temp changes (cold feet) ☐ paresthesias ☐ edema.
Ortho:

Neuro: ☐ absent light touch toes ☐ absent protective threshold

Derm: Nails are ☐ mycotic, ☐ hypertrophic/thickened, ☐ discolored, ☐ long, ☐ incurvated, ☐ brittle,
☐ positive subungual debris, ☐ ingrown
Hyperkeratotic lesions/HKs and tylomas are located ☐ submetatarsal, ☐ hallux pinch,
☐ multiple digits, ☐ B/L

Vasc: ☐ Hx of amputation to part of limb (non traumatic)
☐ absent posterior tibial ☐ absent dorsalis pedis
☐ decreased hair growth ☐ pigmentary changes ☐ skin color (red or rubor)
☐ skin texture (thin, shiny) ☐ increased temp gradient ☐ edema (pitting)

Other:

A/P:

Date

12/20/21

The above patient was seen in the office with the chief complaint of ☐ painful, ☐ long, and ☐ thicken ☐ nails and ☐ calluses.
The feet are painful with shoe gear and ambulation.
The above patient indicates that the debridement of the above is helpful.
The above denies ☐ nausea, ☐ vomiting, ☐ fever, and ☐ chills.
The above states that their blood sugar is ☐ under control ☐ not controlled.
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Vasc: ☐ Hx of amputation to part of limb (non traumatic)
☐ absent posterior tibial ☐ absent dorsalis pedis
☐ decreased hair growth ☐ pigmentary changes ☐ skin color (red or rubor)
☐ skin texture (thin, shiny) ☐ increased temp gradient ☐ edema (pitting)

Other:

A/P:

Good documentation Code 11056

Patient: XXXXX Account No: XXXXX Date: 9/16/2019

This 80 year(s) F presents today complaining of a painful hammertoe deformities of the right, left foot. These deformities have been present for several years gradually becoming worse causing increasing pain when walking, standing and wearing shoe gear. The pain is currently a 5 on a scale of I to 10. Patient has attempted self-treatment in the form of padding, roomy shoe gear and OTC NSAIDs with little if any improvement.

Review of Systems

Constitutional : WNL
Eyes : WNL
ENTM : WM.,
Integumentary : WNL
Allergic : WNL
Musculoskeletal : intermittent pain in ball of right foot
Neurological: WN L
Genitourinary: WNL
Endocrine: WNL
Respiratory: WNL
Gl: WNL
CVS: WNL
Hematologic: WNL
Psychiatry: WNL

No Active Meds
No Significant Past Medical History
No Significant Past Surgical History
NKDA

On exam the patient's right, left foot exhibits flexible hammertoe deformities with bursitis and swelling over the PIPJ's, DIPJ's.
There is no crepitus on ROM. Patient relates that there is pain when pressure is applied to the hammertoes dorsally.
There are painful HD formations on the medial side of #2 left and right foot
Assessment: Hammertoe deformities of the left, right foot.
Synovitis,bursitis of the deformed digits
Symptomatic HD formations #2 bilaterally.
Plan: Discuss etiology and treatment options of hammertoe deformity with patient including but not limited to prescription strength NSAID's, accommodative shoe gear, orthosis, cortisone injections, physical therapy and surgery.
The risks benefits and alternatives to these treatment options were explained to the patient.
Debride painful HD formations #2 bilaterally with #10 blade and apply neosporin dispersion dressings.
Accommodative shoe gear is also recommended.
PTR 2 months or as needed
Assessment:
Idiopathic peripheral neuropathy bilaterally extending half way up the legs

Plan: Discuss etiology and treatment options with patient including but not limited to prescription strength NSAID's, accommodative shoe gear, orthosis, cortisone injections, physical therapy and surgery.
The risks benefits and alternatives to these treatment options were explained to the patient.
Accommodative shoe gear is also recommended.
Signed Electronically By XXXXX on Monday, September 16, 2019 12:03:36 PM (Eastern Daylight Time)

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Bad Documentation Code 11055

Dates of Service: 10/29/2019
Procedure Code: 11055

PODIATRY CONSULTATION
Resident Name: Room:
Date of Referral: Referring Physician:
Diagnosis/Reason for Consult:
[ ] Diabetes [ ] PVD [ ] Neuropathy. [ ] Mycotic Nails [ ] Other:_____
Medical History: h

Reviewed PMHx, Medications and ROS

FINDINGS:		LEFT	RIGHT
SKIN:	TEMPERATURE		
	FUNGAL INFECTION		
	DRY SKIN		
	CORNS Location		
	CALLUSES Location		
	HAIR		
	SKIN TEXTURE		
	CYANOSIS		
	RUBOR		
NAILS: CIRCLE AFFECTED NAILS	LONG		1 2 3 4 5
	DYSTROPHIC	1 2 3 4 5	1 2 3 4 5
	HYPERTROPHIC		1 2 3 4 5
	DISCOLORED	1 2 3 4 5	1 2 3 4 5
	SUBUNGUAL DEBRIS	1 2 3 4 5	1 2 3 4 5
	PAIN UPON PALPATION	1 2 3 4 5	1 2 3 4 5

FINDINGS:		LEFT	RIGHT
ARTERIAL	DP PULSE		
	PT PULSE	4	
VENOUS	VARICOSITIES		
	STASES		
EDEMA	PITTING		
	NON-PITTING		
ULCERATIONS:			
NEURO	PARESTHESIA		
	MOTOR DEFICIT		
	BURNING		
	SENSORY DEFICIT		
	PERIPHERAL NEUROPATHY		
AMPUTATIONS (Specify)			
DEFORMITIES	HALLUX VALGUS		
	HAMMER TOES		
	OTHER		

ADDITIONAL FINDINGS:

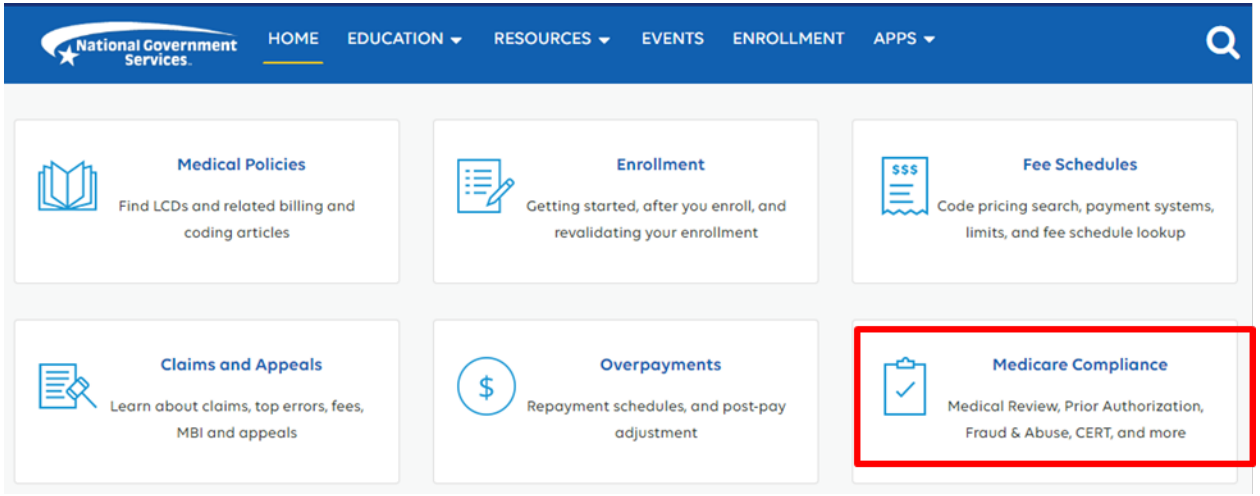
DIAGNOSIS: [ ] PVD [ ] Onychomycosis [ ] Long Nails [ ] Diabetes [ ] Xerosis [ ] Tinea Pedis
[ ] HPK x ___ [ ] Other: _____

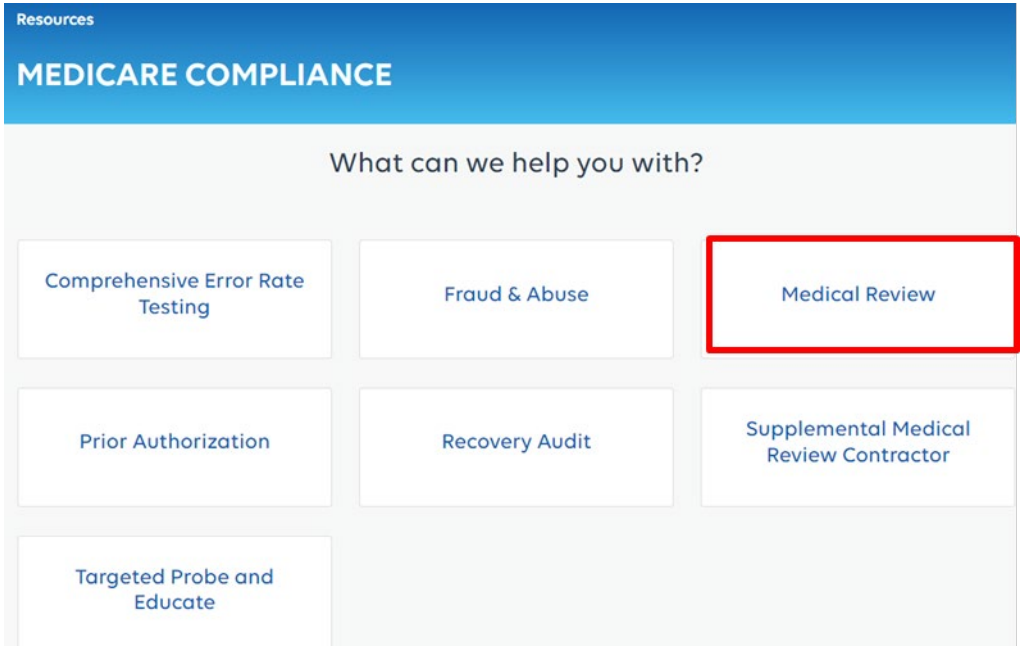
PLAN OF CARE/ RECOMMENDATIONS: [ ] Evaluation [ ] Debrided Nails x _____
[ ] Trimmed Nails x 10 [ ] Debrided Hyperkeratotic Lesions x _____
[ ] Recommend Daily moisturizer w/ Amlactin or similar to decrease risk of fissures.
[ ] Monitor pressure areas.
Other: _____
FOLLOW UP: [ ] PRN [ ] 2-3 MONTHS [ ] Other: _____

Signature of P[redacted] Date 10/29/19 Signature of Physician/NP Date

Medical Review – Targeted Probe & Educate (TPE)

Medical Review





national government SERVICES

NGS MU

Medical Review

TPE MANUAL

What is the Targeted Probe and Educate?

As directed by CMS, effective 10/1/2017, National Government Services Medical Review transitioned all lines of business to a TPE strategy. The purpose of this transition is to reduce costs related to improper payments and appeals, therefore reducing provider burden through one-on-one help.

Home health and SNF demand bill review are CMS mandated reviews and will not transition to TPE.

Providers selected for TPE will receive a notification letter from us (enclosed in a pink envelope) via USPS. The notification letter will provide details about TPE, it will also include our educational email address. In addition, we are asking providers to notify us using the shared mail box, of a delegated contact associate from their facility who could answer any questions we may have regarding their TPE review, requests for additional information and serve as a contact name for our TPE correspondence. Providers are requested to submit the contact information to our shared email address and include the contact name, provider name, provider number, email address and phone number.

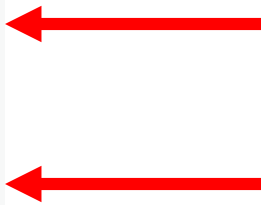
Key Elements of TPE

- Up to three rounds of prepayment TPE. If the provider's error rate remains high upon completion of the first round, then the provider is retained for the second and, potentially, a third round of review.
  - Automated reviews and prior authorization directed by CMS are outside of the TPE strategy.
  - Note that any reviews or pilots otherwise mandated by CMS are excluded from this change.
- Providers with a continued high error rate after three rounds of TPE will be referred to CMS for additional action.
- Your MAC will select the topics for review based upon existing data analysis procedures.
- The claim sample size for each round of probe review is limited to a minimum of 20 and a maximum of 40 claims.

JK Targeted Probe and Educate

Targeted Probe and Educate: Medical Review Topics

Topic	CPT Code
Paring or Cutting of Benign Hyperkeratotic Lesion	11055, 11056, 11057
Vitamin D Assay	82306
Trimming of Nondystrophic Nails and/or Nail Debridement	11719, 11720, 11721
Hyaluronan or Derivative, Gel-One or Monovisc, for Intra-Articular Injection	J7326, J7327, 20610, 20611
Breast Ultrasound	76641
Botox (Botulinum Toxins)	J0585, 64612, 64615
Extracapsular Cataract Removal	66984
Psychiatric Diagnostic Evaluation	90791
Psychotherapy	90837
Outpatient Physical Therapy, Occupational Therapy, and/or Speech Language Pathology	All therapy codes when billed with KX modifier



Resources

- Medical Policy Center - Part B
- LCD for Routine Foot Care and Debridement of Nails (L33636)
- Local Coverage Article for Billing and Coding: Routine Foot Care and Debridement of Nails (A57759)
- Local Coverage Article for Removal of Benign Skin Lesions (A54602)
- LCD Incision and Drainage (I & D) of Abscess of Skin, Subcutaneous and Accessory Structures (L33563)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Sections 30.6.1, 30.6.6, 30.6.14, 30.6.14.1 and 40.4
- Medicare Coverage Database
- PTP Coding Edits | CMS

Billing Tips to Avoid Costly Appeals

Specific Items to Look For

- ICD-10 codes that support medical necessity
  - There may be multiple groups of ICD-10 codes
  - It is important to read the narrative at the beginning of each ICD-10 group to understand which CPT codes apply to the list of ICD-10 codes

ICD-10 Codes that Support Medical Necessity

- Group 1 Paragraph
  - Codes: 11055, 11056, 11057, 11719, 11720, 11721 and G0127
- Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation

  * For these diagnoses, the patient must be under the active care of a doctor of medicine or osteopathy **(MD or DO)** for the treatment and/or evaluation of the complicating disease process during the six month period prior to the rendition of the routine-type service

Treatment of Mycotic Nails, Onychogryphosis or Onychauxis

- Codes: 11719, 11720, 11721 and G0127
- In the absence of a systemic condition or where the patient has evidence of neuropathy, but no vascular impairment, for which class findings modifiers are not required these ICD-10 CM codes must be reported as primary
  - B35.1 Tinea unguium
  - L60.2 Onychogryphosis
  - L60.3 Nail dystrophy
- The diagnosis representing the patient's symptom must be reported as the secondary ICD-10-CM code
  - Refer to Group 3 for the secondary ICD-10-CM codes required for coverage

Group 4 Paragraph

- 11055, 11056, 11057, 11719, 11720, 11721 and G0127
- The ICD-10-CM codes in the Group 4 paragraph represent those diagnoses where the patient has
  - Evidence of neuropathy
  - No vascular impairment
  - Class findings modifiers are not required
    - Refer to LCD in Group 4 codes

Claim Submission Requirements

- Date last seen by **primary** physician
  - The approximate date when the beneficiary was last seen by the **MD/DO** who diagnosed the complicating condition must be reported in an eight-digit format in Item 19 of the CMS-1500 claim form or the electronic equivalent

Billing Tips

- Procedure codes may be subject to NCCI edits, prior to billing Medicare refer to CMS National Correct Coding Initiatives Edits
- A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act
- The diagnosis code(s) must best describe the patient's condition for which the service was performed
- For diagnostic tests report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported

Billing Tips

- ABN guidelines
  - An ABN may be used for services which are likely to be noncovered, whether for medical necessity or for other reasons
    - Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 30, for complete instructions
  - MLN® Educational Tool: *Advance Beneficiary Notice of Non-coverage Interactive Tutorial - ICN MLN909183*

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

- You are not required to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit
- As a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability
- Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice
  - MLN® Booklet *Items & Services Not Covered Under Medicare*

Documentation Requirements

- Refer to the LCD for documentation requirements specific to the service being rendered and billed
- Document physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement
- Physical findings and services must be precise and specific (e.g., left great toe, or right foot, 4th digit)
- Documentation of coexisting systemic illness should be maintained

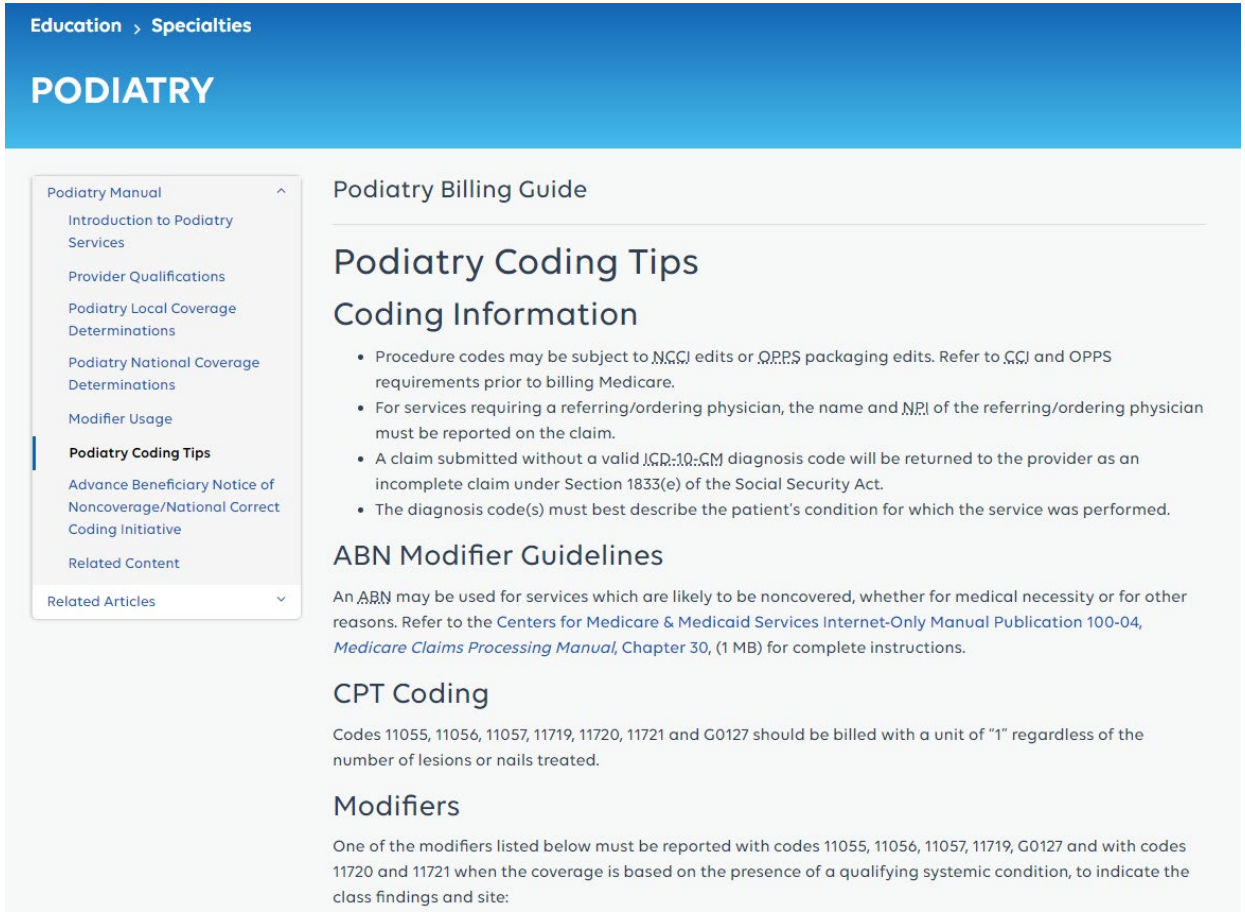
Utilization Guidelines

- Routine foot care services are considered medically necessary once in 60 days
- More frequent services will be considered not medically necessary
  - 60-day calculations are available
    - Podiatry Calculator
- Services for debridement of more than five nails in a single day may be subject to special review

Global Surgery Rules

- The global surgery rules will apply to routine foot care procedure codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127
- As a result, an E/M service billed on the same day as a routine foot care service is not eligible for reimbursement unless the E/M service is a significant separately identifiable service, indicated by the use of modifier 25, and documented by medical records
- If the patient has evidence of neuropathy BUT no vascular impairment, the use of class findings modifiers is not necessary

Podiatry Coding Tips



Education › Specialties

PODIATRY

Podiatry Manual
- Introduction to Podiatry Services
- Provider Qualifications
- Podiatry Local Coverage Determinations
- Podiatry National Coverage Determinations
- Modifier Usage
- **Podiatry Coding Tips**
- Advance Beneficiary Notice of Noncoverage/National Correct Coding Initiative
- Related Content

Related Articles

Podiatry Billing Guide

Podiatry Coding Tips

Coding Information

- Procedure codes may be subject to NCCI edits or OPPS packaging edits. Refer to CCI and OPPS requirements prior to billing Medicare.
- For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.
- A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.
- The diagnosis code(s) must best describe the patient's condition for which the service was performed.

ABN Modifier Guidelines

An ABN may be used for services which are likely to be noncovered, whether for medical necessity or for other reasons. Refer to the Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, (1 MB) for complete instructions.

CPT Coding

Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127 should be billed with a unit of "1" regardless of the number of lesions or nails treated.

Modifiers

One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127 and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, to indicate the class findings and site:

How Providers Can Avoid Costly Appeals

- Verify procedure code (s) are appropriate based on medical records
- Use modifiers when applicable
- Number of service(s) and billed amount for each service is correct
- Date last seen by primary physician
  - The approximate date when the beneficiary was last seen by the MD/DO who diagnosed the complicating condition must be reported in an eight-digit format in Item 19 of the CMS-1500 claim form or the electronic equivalent
- NPI of the attending physician
  - The NPI of the attending physician must be reported in Item 19 of the CMS-1500 claim form or the electronic equivalent
  - If this information is not entered on the CMS-1500 claim form/electronic equivalent, it is considered "missing information" and the claim will be returned as unprocessable which assigns responsibility to the provider (CO)
- Use the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim when needed
- Verify primary payer data

Local Coverage Determinations (LCDs)

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | **Medical Policy Articles**

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880

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Additional Medical Policy Topics

Conflict of Interest Disclosure	Contractor Advisory Committee (CAC)	Investigational Device Exemption Request
LCD Open Meetings	LCD Reconsideration Process	Medical Policy Contact Information
New LCD Request Process		

New LCD Request Process (A56198)

- Request considered in our jurisdiction from:
  - Beneficiaries residing or receiving care
  - Healthcare professionals
  - Any interested party
- Request should include:
  - Language that requestor wants included in the new LCD
  - Justification supported by peer-reviewed evidence
  - Full copies of published evidence to be considered
  - Information that addresses the relevance, usefulness, clinical health outcomes or medical benefits
  - Information that fully explains the design, purpose and/or method
- An informal meeting may be requested for discussion of the potential LCD
  - Submit via e-mail

New LCD Request Process

- Request can be sent via e-mail, facsimile or written letter
  - Email: NGSnewlcdrequest@anthem.com
  - Fax: (317) 595-4334
    - Attention: New LCD Request
  - Mail:
    - National Government Services, Inc.
      Medical Policy Unit
      Attention: **New LCD Request**

      P.O. Box 7108
      Indianapolis, IN 46207-7108

Article for LCD Reconsideration Process (A52842)

- Requesting a revision to a **final** LCD
- Submit written request
- Identify language that requestor wants added/deleted from LCD
- Copies of published authoritative evidence
  - Scientific data or research studies published in peer-reviewed medical journals not previously reviewed or listed in sources of information
  - Consensus of expert medical opinion (recognized authorities in the field)
  - Medical opinion derived from consultations with medical associations or other healthcare experts

Reconsideration Process

- Submission of electronic request is preferred
  - Email: NGS.lcd.reconsideration@anthem.com
  - Fax: (317) 595-4334
- Mail to:
  - National Government Services, Inc.
    Medical Policy Unit
    Attention: LCD Reconsideration Request
    P.O. Box 7108
    Indianapolis, IN 46207-7108

Requesting Addition of ICD-10 Code

- Providers may request that an LCD be **revised** to **add coverage for additional diagnosis codes**
- Does not qualify as a reconsideration
- Can send a request to
  - ✓ Email: NGS.lcd.reconsideration@anthem.com
- Include clinical rationale if no peer-reviewed literature is available
  - Remember no PHI or PII can be sent electronically

LCD Open Meetings

- Held for each LCD development cycle
- Notice of meeting is posted with location and time of meetings about one month in advance
- Medical Policy Section of the Web site
- Open to the public
- In person or teleconference participation available

Medical Policy Unit Contact

- Clinical issues related to Medicare coverage
  - Submit to our Contractor Medical Director
    - Email: NGSCMD@elevancehealth.com
- General inquiries related to Medicare coverage, local and national coverage determinations, billing and reimbursement must be directed to our Provider Contact Center
  - JK: 866-837-0241
  - J6: 866-234-7340

Preventive Services

Preventive Services Educational Tool

- Learn About Codes
- Who is Covered
- Frequency
- What the Beneficiary Pays
- ICD-10-CM Codes

MLN Educational Tool – Preventive Services Chart (ICN 006559)

Alcohol Misuse Screening & Counseling (T)	Annual Wellness Visit (T)	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Cervical Cancer Screening	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use (T)
Depression Screening (T)	Diabetes Screening	Diabetes Self-Management Training (T)	Flu Shot & Administration	Glaucoma Screening	Hepatitis B Screening	Hepatitis B Shot & Administration
Hepatitis C Screening	HIV Screening	IBT for Cardiovascular Disease (T)	IBT for Obesity (T)	Initial Preventive Physical Exam	Lung Cancer Screening (T)	Mammography Screening
Medical Nutrition Therapy (T)	Medicare Diabetes Prevention Program	Pap Tests Screening	Pneumococcal Shot & Administration	Prolonged Preventive Services (T)	Prostate Cancer Screening	STI Screening & HIBC to Prevent STIs (T)
Screening Pelvic Exams	Ultrasound AAA Screening					

FAQs

▲ Quick Start ▲ Advance Health Equity

MLN006559 September 2022

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Thank You!

- Questions?

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