Podiatry Coding

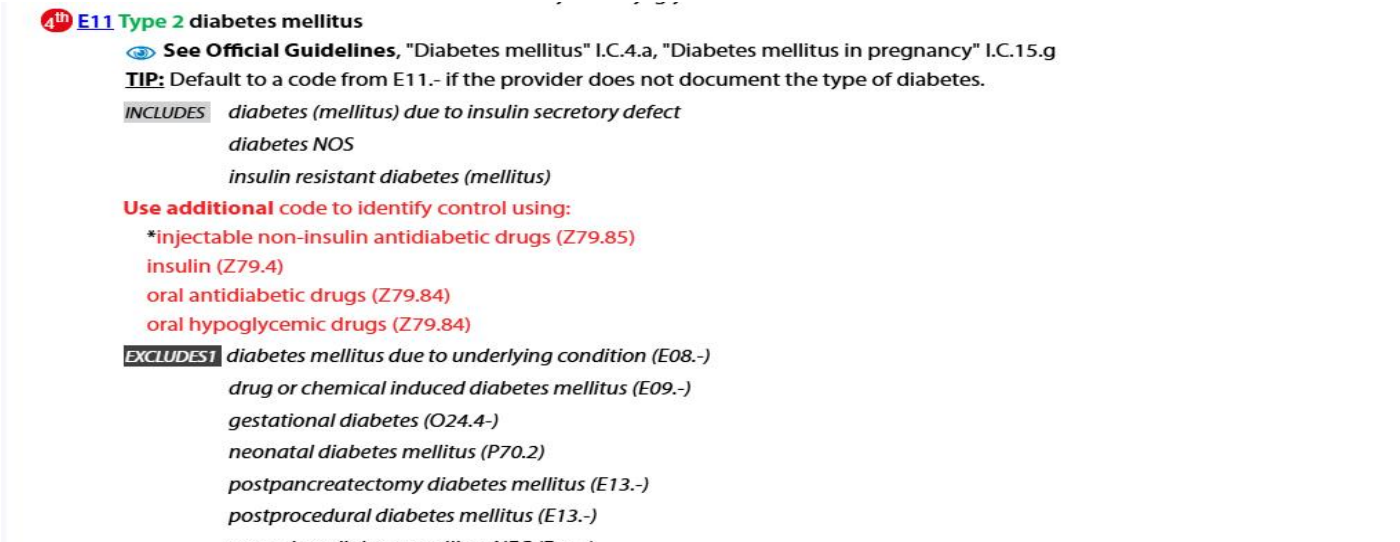
Some Pearls for Success

What is the correct ICD-10 for non-complicated T2 DM?

E11.9 alone

Not exactly

According to ICD-10 book there should be an additional code



4th E11 Type 2 diabetes mellitus

See Official Guidelines, "Diabetes mellitus" I.C.4.a, "Diabetes mellitus in pregnancy" I.C.15.g

TIP: Default to a code from E11.- if the provider does not document the type of diabetes.

INCLUDES *diabetes (mellitus) due to insulin secretory defect*
diabetes NOS
insulin resistant diabetes (mellitus)

Use additional code to identify control using:
*injectable non-insulin antidiabetic drugs (Z79.85)
insulin (Z79.4)
oral antidiabetic drugs (Z79.84)
oral hypoglycemic drugs (Z79.84)

EXCLUDES1 *diabetes mellitus due to underlying condition (E08.-)*
drug or chemical induced diabetes mellitus (E09.-)
gestational diabetes (O24.4-)
neonatal diabetes mellitus (P70.2)
postpancreatectomy diabetes mellitus (E13.-)
postprocedural diabetes mellitus (E13.-)

Wounds

6th E11.62 Type 2 diabetes mellitus with skin complications

E11.620 Type 2 diabetes mellitus with diabetic dermatitis HCC RxHCC

Type 2 diabetes mellitus with diabetic necrobiosis lipoidica

E11.621 Type 2 diabetes mellitus with foot ulcer HCC RxHCC

AHA: Q1 2020, Q2 2020, Q1 2016

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

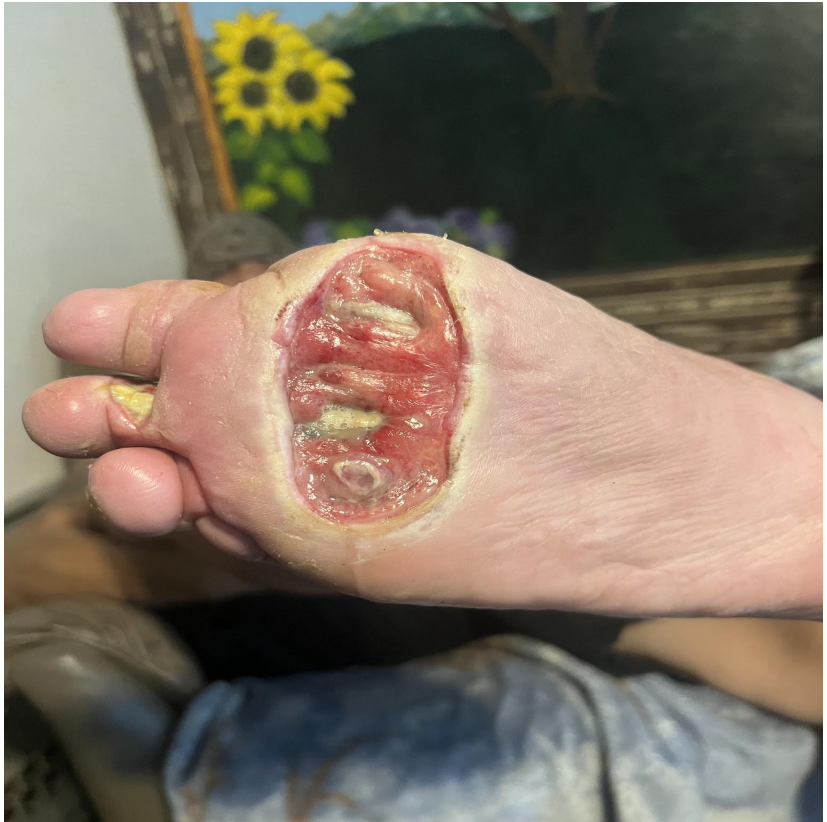
E11.622 Type 2 diabetes mellitus with other skin ulcer HCC RxHCC

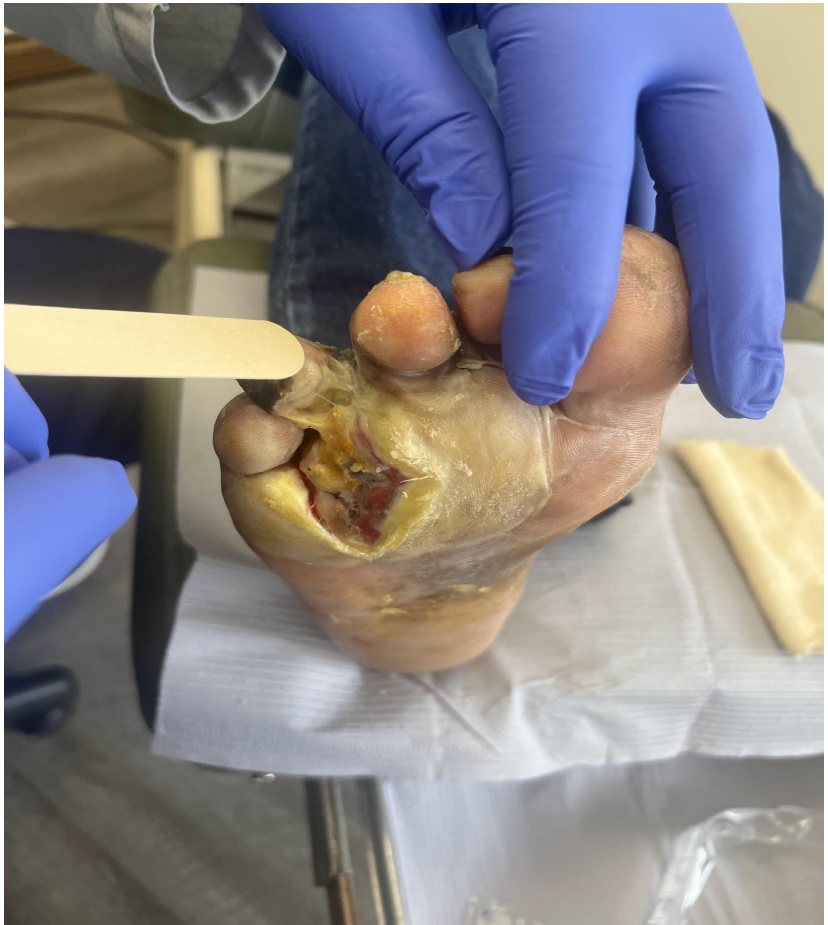
AHA: Q1 2021

Use additional code to identify site of ulcer (L97.1-L97.9, L98.41-L98.49)

E11.628 Type 2 diabetes mellitus with other skin complications HCC RxHCC

Let’s do some debridements….





Debridement

Wound debridements (11042-11047) are reported by depth of tissue that is removed and by surface area of the wound. These services may be reported for injuries, infections, wounds and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths. For example: When bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq cm dehisced abdominal wound and a 10 sq cm thigh wound, report the work with 11042 for the first 20 sq cm and 11045 for the second 6 sq cm. If all four wounds were debrided on the same day, use modifier 59 with either 11042, or 11044 as appropriate.

LCD

Routine Foot Care L33636

Great to review but the key is read and understand A57759

Billing and Coding article for RFC

ICD-10 and CPT codes

National Coverage Provisions:

The following services are considered to be components of routine foot care, regardless of the provider rendering the service:

- *The 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;
- Non-definitive simple, palliative treatments like shaving or paring of plantar warts which do not require thermal or chemical cautery and curettage;
- *Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.*

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Treatment of mycotic nails or onychogryphosis, or onychauxis (codes 11719, 11720, 11721 and G0127 may be covered under the exceptions to the routine foot care exclusion when one of the situations below is present:

1. Systemic conditions with adequate documentation of class findings as outlined above, and the use of the appropriate modifier, indicating the presence of qualifying systemic illnesses causing a peripheral neuropathy. Payment may be made for the debridement of a mycotic nail (whether by manual method or by electrical grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit and the physician attending the mycotic condition documents that the criteria are met; OR

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2. In the absence of a systemic condition, the following criteria must be met:

- In the case of ambulatory patients there exists:

  Clinical evidence of mycosis of the toenail, and

  Marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

- In the case of non-ambulatory patients there exists:

  Clinical evidence of mycosis of the toenail, and the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

The examination includes:

A patient history, and

A physical examination that must consist of at least the following elements:

Visual inspection of forefoot and hindfoot (including toe web spaces);

Evaluation of protective sensation;

Evaluation of foot structure and biomechanics;

Evaluation of vascular status and skin integrity;

Evaluation of the need for special footwear; and

Patient education.

Coding Information:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI 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. For diagnostic tests report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

In addition, the beneficiary may have complicated diagnosis(es) that require them to be under the care of a primary physician for the disease that is causing the beneficiary to seek provider based routine foot care. For the asterisked conditions below, the name of the primary physician (must be a D.O. or M.D.) who made the diagnosis, and the approximate date of the last visit should be included in the record and entered on the appropriate claim forms or electronic equivalent when billing Medicare per the Benefit Policy Manual noted above. Please refer to the CMS website for instructions for billing Part A and Part B claims.

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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.*)

Coding Information/Limitations

1. Covered exceptions to routine foot care services are considered medically necessary once (1) in 60 days. More frequent services will be denied as not reasonable and necessary.

2. The exclusion of foot care is determined by the nature of the service, regardless of the clinician who performs the service.
3. Medicare allows payment for routine foot care only if the conditions under indications are met. These conditions describe the systemic diseases and their peripheral complications that increase the danger for infection and injury if a non-professional provides these services.
4. Services not meeting the criteria in this statement of national coverage will be denied as statutory non-covered services. For diagnosis codes designated by an asterisk (*), we will require the date the patient was last seen (DPLS) and the NPI of the Doctor of Medicine or Doctor of Osteopathic Medicine actively managing the patient's systemic condition.
5. Nail debridement procedures are considered non-covered routine foot care when these services do not meet the guidelines outlined above for mycotic nail services or are not based on the presence of a systemic condition. If the nail debridement procedures are performed in the absence of mycotic nails and as part of foot care, they must meet the same criteria as all other routine foot care services to be considered for payment.
6. Foot care services that do not require a professional would be considered routine and not a Medicare benefit. Professional in this situation is defined as an M.D., D.O., D.P.M., Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant.
7. **Effective for dates of service on or after December 1, 2023**, a Registered Nurse that holds foot care certification such as Certified Foot Care Nurse (CFCN®) or Certified Foot Care Specialist (CFCS) or other similar certifications or independent training by supervising professionals may perform covered foot care services when all the following requirements are met:
    - Services are performed under direct supervision of a physician or other practitioner
    - All requirements of the "incident to" provision are met per the CMS Medicare Benefit Policy Manual
    - Proof of accredited Foot Care Nurse certification must be available for NGS on request
    - All other coverage provisions outlined in this Billing and Coding Article are met
    - *Providers should be aware that this may not be allowed, based on their state scope of practice laws.*

Group 1 (3 Codes)

Group 1 Paragraph

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. If the patient has evidence of neuropathy, but no vascular impairment, class findings modifiers are not required:

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.

E11.49*
E11.51*
E11.52*
E11.59*
E11.610*
E13.42*
E13.49*

I70.90
I70.91
I73.00
I73.01

Group 1 Medical Necessity ICD-10-CM 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 (6) month period prior to the rendition of the routine-type service.

THANK YOU