Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Medicare Might Pay for Mycotic Nail Debridement

Know frequency limitations for **CPT 11720** and **CPT 11721** .

If Medicare routinely denies claims you submit with 11720 or 11721, take heart: Many carriers actually cover debridement. Read on for simple ways to avoid denials and recoup your rightful payment for "routine foot care."

Follow Criteria for Procedure Codes

When it's time to report mycotic nail debridement, you have three coding choices:

• 11720 -- Debridement of nail(s) by any method(s); one to five

• 11721 -- ... 6 or more

• G0247 -- Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e.,superficial to muscle and fascia) and at least the following if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails.

Extra tip: Remember that certain criteria apply when you report any of these codes. For example, carriers only reimburse 11720 and 11721 when the patient has an infection and pain during ambulation.

Among many carriers' diagnosis requirements for debridement coverage is the presence of a systemic condition (such as metabolic, neurological, or peripheral vascular diseases) causing potential risk if the patient performed the debridement himself.

These systemic conditions can result in either severe circulatory or neurological problems in the legs and feet and lead to complications, says **Richard D. Odom, DPM, CPC,** a podiatrist in Spanish Fort, Ala. They aren't always necessary for your reimbursement purposes, however. "You already have the 'systemic condition,' so nothing else is needed," says **Paul Fehring,** owner of Drs. Central Billing LLC in Fairfield, Ohio.

Policy check: Even if your carrier considers mycotic nail debridement to be part of routine foot care, review the policy for special circumstances. TrailBlazer in Colorado, New Mexico, Oklahoma, and Texas, for example, includes the following exception in its Local Coverage Determination (LCD): "Treatment of mycotic nails may be covered in the absence of a qualifying covered systemic condition if there is clinical evidence of mycosis of the toenail, and the patient has marked limitation of ambulation, pain, or secondary soft tissue infection resulting from the thickening and dystrophy of the infected nail plate."

Clue in to symptoms: Don't think, however, that you can continue receiving reimbursement for nail care once your patient's mycotic symptoms lessen. TrailBlazer's policy continues with, "The treatment of mycotic nails in the absence of a qualifying covered systemic condition will not be covered after the acute symptoms caused by mycosis have abated."

Track Down the Best Diagnosis

Most LCDs include a list of acceptable ICD-9 codes that justify debridement of mycotic nails. Two common requirements are a primary diagnosis of 110.1 (Dermatophytosis of nail) and a secondary diagnosis, such as 729.5 (Pain in limb).

The key is having a reliable method for keeping these carriers' individual debridement requirements straight. Tracking

things is simple if the patient has pain because you report 110.1 and 729.5.

If the patient is not experiencing pain, however, Fehring says you should report 110.1 and list a systemic ICD-9 code as a secondary diagnosis (such as 440, Atherosclerosis).

Don't forget the Q: Also append the appropriate Q modifier to 11721, depending on your podiatrist's findings related to thepatient's condition (Q7, One class A finding; Q8, Two class B findings; or Q9, One class B and two class C findings).

Since you would normally use 11720 and 11721 to report mycotic nail debridement, it's helpful to know that LCDs for 11720 and 11721 are fairly similar across the nation. But the biggest difference is the frequency that carriers allow. You can only bill for the service every 61 days in Ohio, Fehring says. "That is typical of at least 90 percent of the states," he adds.

Follow Documentation Steps

Even if you have the proper diagnoses in line and know the nail debridement services are covered within the correct timeframe, that doesn\'t guarantee payment. You still need to supply the proper documentation -- and each carrier has its own idea of what that includes. Most carriers require a description of each nail treated and a description of the debridement procedure to indicate that it was more than routine foot care. Keep these simple tips from Fehring in mind when checking your podiatrist's documentation:

• Verify if your carrier expects certain verbiage, such as Ohio requiring a claim note with the statement, "Nails are thick, yellow, and crumbly."

• State in the notes that the physician "debrides" the nails, not "cuts."

• Document which toes are painful due to the nails being mycotic.

• When you report a systemic condition, most carriers require that your podiatrist document the treating physician (MD or DO) and the date of the patient's last visit within the last six months.

In addition, some carriers want a description of the specified condition beyond a mere mention that the particular condition is present. This means there should be a clinical rationale considering the patient's usual activities, TrailBlazer's LCD states.

Best bet: Teach your physician to document which specific nails are painful and how the painful nails limit the patient's activities in the patient's own words, whenever possible.

Heads up: If you report to Empire Medicare Services, read your LCD closely for documentation requirements. Empire specifically notes that its physicians must include at least a description of the nail's size, thickness, and color, plus "the local pathology caused by each affected nail resulting in the need for debridement." Empire also specifies that if the physician performs and bills cultures, you must have documentation of the cultures and the need for prolonged oral antifungal therapy in the patient record. Plus, services for debridement of more than five nails in a single day may be subject to special review so you'd better have good documentation in the patient's medical record to support medical necessity in those cases.

Prepare Your ABN Forms

Some patients request routine foot care but don't have the diagnoses to justify billing it to insurance carriers. Don't let this keep your podiatrist from providing the service, however, because some patients may be willing to pay for it themselves.

Medicare tip: Medicare will never cover routine foot care for asymptomatic patients because it is on a specific list of "exclusions" from Medicare benefits. Therefore, CMS recommends (although it doesn't require) that you ask the patient to sign an advance beneficiary notice (ABN), which now includes what used to be referred to as a notice of exclusions from Medicare benefits (NEMB) form.

Having the patient sign the ABN will remind her that Medicare won't cover the procedure and that you can bill her for it.