Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Secure Nail Care Pay With This Expert Advice

Don't forget to use modifiers and appropriate diagnosis codes to prevent denial.

While routine nail care reporting might seem easy, the difference between getting paid for the procedure and denials is a thin line. You can enjoy reporting success by understanding coverage guidelines and what to look for in the supporting patient documentation.

Observe Coverage Criteria For Routine Nail Care

Medicare will not provide coverage for routine nail care such as clipping, trimming, or debridement of nails (including trimming of mycotic nails). But you can report routine nail care separately if the patient has a systemic condition, such as metabolic, neurologic, or peripheral vascular disease, of sufficient severity that it will put the patient at risk if the nail care is performed by a non-professional. Examples include (but are not limited to):

- Diabetes mellitus
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitisobliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet -
- Associated with malnutrition and vitamin deficiency

 Malnutrition (general, pellagra)
 Alcoholism
 Malabsorption (celiac disease, tropical sprue)
 Pernicious anemia

- Associated with carcinoma
- Associated with diabetes mellitus
- Associated with drugs and toxins
- Associated with multiple sclerosis
- Associated with uremia (chronic renal disease)
- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders
- Hereditary sensory radicular neuropathy
- Angiokeratomacorporisdiffusum (Fabry's)
- Amyloid neuropathy

So, when billing for routine nail care, your claim for the procedure should be accompanied by a covered diagnosis. If no systemic conditions are present, the care can still be reported if the patient has clinical evidence of mycosis of the nails and is suffering from pain, secondary infection, or limitation of ambulation due to the condition. Apart from this, nail care can be reimbursable when accompanied by the following diagnoses:

- Onychogryphosis
- Onychauxis

When nail care or other routine foot care is provided to a patient with a systemic condition, you need to document class findings in the patient record to support the medical necessity and presumption of coverage in providing this service. Class A findings mean "non-traumatic amputation" of the foot, or integral part of the foot skeleton. Class B findings include absent posterior tibialor dorsalispedispulse, or three of the following advanced trophic changes:

- hair growth (decrease or absence)
- nail changes (thickening)
- pigmentary changes (discoloration)
- skin texture (thin, shiny)
- skin color (rubor or redness).

Class C findings include edema, claudication, temperature changes, and abnormal sensations such as burning. The presumption of Medicare coverage may be applied when the physician rendering the routine foot care has identified:
1. A Class A finding;
2. Two of the Class B findings; or
3. One Class B and two Class C findings.
Use appropriate modifiers: You'd use modifier Q7 to indicate one Class A finding, modifier Q8 to indicate two Class B findings, or modifier Q9 to indicate one Class B finding and two Class C findings.

Choose Appropriate Codes Based on Procedure and Health of Toenail
When reporting a nail care procedure code, you will have to concentrate on what procedure your physician performed along with checking the health of the toenail on which the procedure was done.
If your physician only reduced the length of the nail, then you will have to report one of the trimming codes based on the health of the toenails:

- G0127 (Trimming of dystrophic nails, any number)
- 11719 (Trimming of nondystrophic nails, any number).

You report G0127 if your clinician is trimming down dystrophic nails and report 11719 if your physician is working on trimming healthy nails.

Coding tip: If you see the descriptors to G0127 and 11719, it mentions the term, "any number." So, you only report one unit of G0127 or 11719 irrespective of the number of toenails that your clinician trimmed. Non-Medicare payers may also require you to report HCPCS Level II code S0390 (Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions [e.g. diabetes], per visit) along with 11719.
You will have to report a debridement code if your physician is intending to remove excessive material (e.g., to significantly reduce nail thickness/bulk) or excessive curvature from a clinically and significantly thickened dystrophic or diseased nail. You report one of the following codes depending on the number of toenails on which your clinician performed the debridement:

- 11720 (Debridement of nail[s] by any method[s]; 1 to 5)
- 11721 (Debridement of nail[s] by any method[s]; 6 or more)

Heads up: Note that 11721 is not an add-on code to 11720. You report 11720 if your clinician performed debridement of one to five nails. If your clinician is working on six or more nails, you only report 11721.
Exercise Caution in Reporting Same Session Trimming and Debridement
If you are planning on reporting a trimming code and a code for debridement for the same patient on the same calendar date of service, you will need to note that these codes will face edit bundles according to Correct Coding Initiative (CCI) edits. "In both edits, the column 1 service is the trimming code, 11719," observes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "When code 11720 is the column 2 code, the modifier indicator is '1,' which means you can override the edit by using a modifier appended to 11720. However, for the edit with code 11721 in column 2, the modifier indicator is '0,' which means that you cannot override the edit with a modifier," adds Moore.

So, if you are reporting 11719 and 11720 for the same session, you will have to append the modifier 59 (Distinct procedural service) to the debridement code (11720) as this is the code that is listed by CCI as the column 2 code for the edit bundling with the trimming code, 11719.

However, you will need to provide documentation to show that your clinician performed the trimming and the debridement on separate nails in order to allow the override of the CCI bundling and get reimbursement for both the procedures.

Example: A patient with rheumatoid arthritis turns up for his routine foot care appointment. Your physician performs trimming of his nails. During the trimming, he notices that three of the nails have turned mycotic. He proceeds to perform debridement of these nails and performs trimming of the other healthy nails.

You report the trimming with 11719 and the debridement with 11720. You will have to append modifier 59 to 11720 and provide documentation that your physician performed debridement of the nails that had turned mycotic while he trimmed down the healthy nails, to allow payment for both the procedural codes.

Don't Report an E/M Service Code as a Norm
As CCI bundles the trimming and debridement codes with E/M service codes, you are not allowed to report an E/M service in addition to either a trimming or debridement code unless the documentation clearly establishes that the E/M service was significantly and separately identifiable from the routine nail care. "One way to do this is to note that the reason he is evaluating the patient is different from the reason for the nail procedure, as indicated by distinct diagnosis codes," says Moore. Indeed, if the diagnosis codes for the debridement and the E/M service are too similar, many carriers consider the conditions too closely related and therefore not billable.

But, if the evaluation and management of the patient is significantly and separately identifiable from the routine nail care service that your physician provides, then you can contemplate reporting the E/M service code additionally. In such a case, you will have to report the E/M code with the modifier 25 appended to it as the E/M codes are the column 2 codes in the CCI edits with nail care codes.

Example: Your physician is providing routine nail care for an established patient with type II diabetes (not stated as uncontrolled) with peripheral circulatory disorder (250.70). During the trimming, your clinician noticed a foot ulcer. He evaluated the new findings. You report the trimming of the nails with 11719 and connect it to diagnosis code 250.70 to help justify the medical necessity of the otherwise routine foot care. In turn, you code the evaluation of the patient for the foot ulcer with an appropriate E/M service, such as 99213 (Office or other outpatient visit for the evaluation and management of an established patient...) and connect it to a primary diagnosis describing the foot ulcer (e.g. 707.15, Ulcer of other part of foot). You will have to append the modifier 25 to the E/M code.
For more information on coverage criteria for routine nail care, check the link at
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.