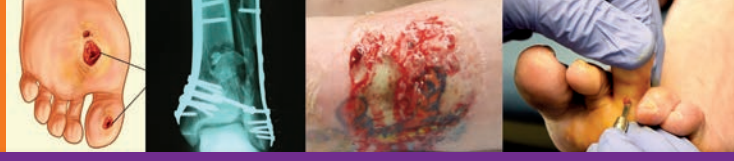

Diabetic Patient Coding Questions

Codingline

These Q & A's recently appeared on Codingline.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

***Q:** If a patient has diabetes, but either doesn't require or does not qualify for therapeutic shoes, can the inserts still be covered if the patient only wants inserts, A5512 (for diabetics only, multiple density insert, direct formed, molded to foot…prefabricated, each), for their regular shoes?*

A: Medicare patients either qualify or do not qualify for the benefits of the Therapeutic Shoes for Persons with Diabetes benefit. To qualify:

- The Medicare patient must be a diabetic; AND
- The MD/DO managing the patient's diabetes ("certifying physician") must document in the medical record one or more of the following conditions:

1) Previous amputation of the other foot, or part of either foot, or

2) History of previous foot ulceration of either foot, or

3) History of pre-ulcerative calluses of either foot, or

4) Peripheral neuropathy with evidence of callus formation of either foot, or

5) Foot deformity of either foot, or

6) Poor circulation in either foot; AND

- The certifying physician must certify that the first two bullet point requirements have been met and that the MD/DO is treating the patient under a comprehensive plan of care for his/her diabetes…and that the beneficiary needs therapeutic shoes and inserts; AND
- The certifying physician must have an in-person visit with that Medicare patient "during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts"; AND
- Sign the certification statement (refer to the Policy Specific Documentation Requirements section below) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

But then you know all that. The question is what if the patient's only qualification was that he or she has diabetes, would Medicare reimburse "inserts for diabetics"? The answer is no. The inserts would not be covered. The patient simply does not qualify for the benefit.

Medicare patients either qualify or do not qualify for the benefits of the Therapeutic Shoes for Persons with Diabetes benefit.

***Q:** I try to do as little routine foot care as possible, but I have some patients, especially my diabetic Medicare patients, who insist on having me to do their non-covered foot care, and bill the service to Medicare. I take great care to let them know that routine foot care is not a covered Medicare service in their case. We have the patient sign an advance beneficiary notice (ABN) prior to performance of the non-covered routine foot care at each visit. They are aware that they would be responsible to pay our office directly for that care. All this is documented in the patient's chart.*

Unfortunately, my Medicare Administrative Contractor (Noridian) often pays the claim rather than denying it…leaving my patients upset with me since they paid out-of-pocket. I try to explain to them that the payment was made in error, and that Medicare will, at some later date, demand the money back, but they remain unhappy.

I am part of a hospital-based medical group and the business office insists on always billing these services even if they are statutorily not covered. The following is an example of a typical non-covered service coding (the patient has no class findings, neurological compromise, or pain reported): CPT 11721 with ICD-10 B35.1 (onychomycosis)

I do not include any additional codes which might validate coverage, but Medicare still approves the claim.

A: The problem is that you are not "telling" your MAC that the routine foot care service you submitted

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on your claim is statutorily non-covered (per your description). You need to append a "GY" (statutorily non-covered) modifier to CPT 11721 to let the Medicare computers know that this patient does not meet the requirements allowing for payment of this palliative service benefit: 1) the patient is not "at risk" for a non-professional to cut their nails or 2) there are no reported symptoms associated with the presence of onychomycosis. One would think that not including all the required ICD-10 codes or "Q" modifiers would get your claim denied, but, obviously, their absence did prevent payment. The "GY" modifier additional will result in your MAC denying the claim.

In terms of claim submission, it is not a requirement that statutorily non-covered services be sent to your Medicare contractor. There are only two (maybe in your case, three) circumstances that would require you to submit a statutorily non-covered claim (with the "GY" modifier): 1) if the patient insists you submit the claim; 2) if you are contracted with the patient's secondary insurer, and need the claim forwarded from Medicare for review/potential payment by the secondary payer; and, in your case, 3) your group business office requires all claims be submitted to Medicare. Again, the good news is that your MAC will deny the claim and send an explanation of benefits (EOB) to you and the patient noting the fee billed for the statutorily non-covered service is the patient's responsibility. More good news: you can collect that money at the time of service, and not wait for the EOB.

Even though you are submitting a "GY" modified claim, it is recommended that you get a written acknowledgement from the patient that you told them (prior to performing the service) that Medicare does not pay for their routine foot care ("the good news is that you are too healthy and have no pain") and that they are directly responsible for payment (and how much).

That is good practice management and helps to avoid future complaints from the patient and/or a family member that you did not tell the patient of the cost to them. You can develop your own form or use the Medicare ABN form. Just because you elect to have the patient sign an ABN or similar form for your office, you would not apply a "GA" modifier to the code. You are not submitting the claim because there is a good possibility that it would get denied for not being medically necessary (e.g., too frequent a service). You are submitting the claim for one of the three reasons above despite the service(s) being statutorily not covered.

Reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

Even though you are submitting a "GY" modified claim, it is recommended that you get a written acknowledgement from the patient that you told them (prior to performing the service) that Medicare does not pay for their routine foot care.

Q: *Can you bill and dispense diabetic shoes to patients while they are in a rehab facility?*

A: If the Medicare beneficiary is in a facility (e.g., skilled nursing facility, hospital, etc.) that is reimbursed through Medicare Part A, then you should stay clear of dispensing any DME (including therapeutic shoes) or supplies. You should also avoid performing therapy (including selective debridement) or taking images (e.g., x-rays, ultrasound) with your own units. Most, if not all, DME for chronic conditions, supplies, therapy, and imaging is reimbursed to the facility under Consolidated Billing rules, and would not be paid separately to you.

If the patient is blessed with being a diabetic without complications ("healthy diabetic"), the patient does not qualify for routine foot care under Medicare.

You need to define "rehab facility" and confirm whether or not the facility is covered under Part A Medicare. If it is, and if you want to be reimbursed for those items or services, you would have to negotiate directly with the facility. Unfortunately, unless you have an agreement in place with the facility prior to dispensing these items or performing Consolidated Billing services, the likelihood of being reimbursed is close to zero.

Q: *My billing company stated that all Medicare Part B new patient visits require the name of the referring primary care physician. If they don't have a physician's name, then the billing company puts my name on the referring line. Is this correct? The billing company also states that if you use diabetes without complications (E11.9) as the diagnosis, that is an automatic denial. What if the patient is well controlled with or without medications, do you look for another diabetic code?*

A: Medicare does require the "referred by" section of the claim to be filled out. For routine foot care (and most other services or proce-

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dures), the referring provider would be the MD/DO or other qualified health provider who actually referred the patient to you. If the patient came to you without such a referral, you would enter your own name in box 17 and your NPI number in box 17b. Your billing company is correct.

Having diabetes is not the qualifier of reimbursed routine foot care. These patients, whether well controlled by diet, oral medications, or insulin, or otherwise uncontrolled, do not qualify for the routine foot care benefit. Medicare reimburses routine foot care in diabetic patients with lower extremity complications or manifestations linked to their diabetes: clinically significant diabetic vascular disease or neurologic loss.

In other words, if the patient is blessed with being a diabetic without complications ("healthy diabetic"), the patient does not qualify for routine foot care under Medicare. Your billing company, again, is correct. As far as "looking for another diabetic code", you code what the patient presents in terms of lower extremity pathology. If it qualifies the patient for the routine foot care benefit, great. If the patient has nothing to qualify them, then they are directly responsibility for payment to you. Cash is good.

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Codingline 2017

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Good News: The APMA Coding Resource Center now includes for its subscribers, for no additional charge, access to CodinglineSILVER through the CRC site. The feature will include an automatic registration and log on. The addition of CodinglineSILVER allows subscribers a "one-stop-shop" of coding resources and a means for asking coding, reimbursement, and practice management questions through the APMA Coding Resource Center. Subscribe to the CRC now—www.apmacodingrc.org.

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.