Documentation of The Top Ten CPT Codes - Part 2

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Editor's note: This is a continuation of the article published in the September issue of Podiatry Management Magazine.

The bottom half of the top ten CPT codes billed by podiatrists are:

6 11719
7 11056
8 11730
9 99202
10 G0127

CPT 11719:

CPT 11719 is defined by the 2002 AMA CPT Manual as the "trimming of a non-dystrophic nail, any number." In other words, CPT code 11719 applies to the trimming (simple reduction of length) of at least one clinically normal nail. Almost every Medicare carrier has a local medical review policy called "routine foot care." This policy is more aptly titled "at risk foot care" since it explains when Medicare will cover CPT 11719 - and that is usually only for patients that are "at risk" for limb loss or infection should a non-professional care for their feet. Routine foot care policies usually contain coverage rules and documentation requirements for CPT codes 11719, CPT 11055-7, and G0127.

All local medical review policies (LMRP's) for routine foot care describe coverage only for "at risk" patients. The concept is that patients are only eligible for coverage when treatment by a non-professional could result in harm to the patient. Therefore, a severe arthritic with crippled hands or a patient without eyesight is not covered by Medicare, as it is assumed that the caregivers responsible for these patients' general hygiene can adequately and safely perform these foot care services without putting the patient at risk.

So who is at risk and eligible for covered at risk foot care? Sadly for patients, it often depends on what state you practice in, what month it is, and what diagnosis you add to the claim form…

* If you practiced in Washington State and certain other states, until earlier this year, and your patient was on coumadin, he or she was considered eligible for at risk foot care - without class findings - but that changed this spring, and now these patients are ineligible.
* If you practiced in Washington State and your patient had a total hip replacement they were also considered eligible for at risk foot care - without class findings - until a few months ago – and now they are considered ineligible.
* If you practiced in Pennsylvania in June 2002 and your patient was a diabetic with lack of protective sensation that did not meet class findings, he or she was non-covered for routine foot care. However, as of July 1, 2002, when the new LOPS (loss of protective sensation) Policy went into effect. These patients now have some Medicare coverage.

* If you practice in New Jersey and your patient has no pedal pulses and you decide she/he has peripheral vascular disease (ICD-9 443.9), the patient is ineligible for coverage– unless you reconsider your diagnosis and submit a claim with unspecified atherosclerosis of the extremities - 440.20 - essentially the same clinical condition.

In most states there is a list of diagnoses within the Routine Foot Care LMRP that Medicare carriers considers comprehensive and eligible for payment. In fact, this list is supposed to be simply "representative " of typical diseases according to the Medicare Carrier's Manual, but in actuality each Carrier only allows coverage for the diseases on their own list by creating computer edits which disqualify all others.

How Does One Document To Medicare That The Patient Is Eligible?

1. If the patient has a diagnosis associated with an asterisk on the list, the podiatric physician must certify on the HCFA 1500 Claim Form that the patient is under the active care of an MD or DO for that condition. The month and year the patient was last seen by the MD or DO needs to be included on the form - in addition to the UPIN of the doctor.
2. If the disease is not associated with an asterisk, the treating DPM usually places his or her name and UPIN on the claim form.
3. The podiatrist needs to append a Q7, Q8, Or Q9 modifier attesting to the fact that the patient not only has the "at risk" diagnosis but also meets "class findings". Patients with these class findings are assumed to have a condition of sufficient severity to warrant Medicare coverage. The specific exam elements that comprise the class findings need to be documented somewhere in the medical record. Do they need to be documented at each encounter? Probably not, but they should be updated periodically. The exception to this is diabetic patients in some states with LOPS – they need no class findings to be eligible for coverage, just documentation of LOPS.

Now What About Diabetics?

Well, if you live in New Jersey and about half the other states in the USA and your patient is diabetic, regularly sees an MD or DO, and suffers the loss of protective sensation (LOPS) s/he is considered eligible for coverage even without class findings. Obviously, if patients meet class findings they are eligible in all states.

If you live in the other half of the states, diabetics that do not meet class findings were not covered for at risk foot care until July 1, 2002 - when the new "LOPS " policy and its 3 "G" codes went into effect. Use of these G codes is a topic for another article.

What should a note look like for at risk foot care?

S: Pt seen for at risk foot care in the office. Offers no pedal c/o
O: Nails elongated x 10. Interdigital spaces clear. No ulcers or infections are noted. Class findings were reviewed on 1/2/2002.
A: Atherosclerosis unspecified
P: Trim 10 nails. Follow up in a few months for at risk foot care, sooner if problems.

The above note should hold up in an audit, provided it is sent in with the note of 1/2/2002 when class findings were documented.

CPT 11056:

The same general rules hold for this code as CPT 11719. There are two important additions:

1. In the objective always document the location of the hyperkeratoses relative to a bony prominence. For example, diffuse tyloma submet 234 right foot, or HD PIPJ toe 5 left.
2. In the plan of the note, state TRIM tyloma x 3 or HD x 1. Avoid the word débride since the CPT defines 11055 series as "paring or cutting" and the 11040 series describes debridement. Remember lay people are often reviewing your records.

It's that simple.

G0127 Code:

This code also has the same requirements in most states in regards to at risk status. The code is defined as "trimming of dystrophic nails, any number". This code is so strange. Some states actually consider this code the most appropriate one to bill for nail debridement when a patient does not have pain (Rhode Island, for example).

In my humble opinion, short of a nail avulsion you have three choices for palliative nail care:

11720/11721: debridement of a nail most often defined as reduction of thickness or girth of a nail

11719: trimming commonly defined as the reduction of length of a non-dystrophic or non- pathological (i.e., normal healthy) elongated nail.

G0127: Trimming reduction of length of a dystrophic nail (per Stedman's dystrophic is "progressive changes that may result from defective nutrition of a tissue or organ."). My definition of a dystrophic nail is any nail which has a disease with some degree of dystrophy. However, the operative word in this CPT code is a verb and that is trimming that is nothing more than the reduction of length of a nail.

Since G0127 and 11719 are equally valued in terms of payment: anytime a normal nail is trimmed, 11719 is appropriate; and when a diseased nail, (for example, white superficial onychomycosis,) is trimmed, it would be properly coded as G0127.

In the real world, patients often present with between one and five nails that are eligible for debridement, and others which require only trimming, making this combination the most common:

11719-QX and 11720-QX-59

A patient has a combination of nails requiring trimming some of which are pathological and some are normal:

11719-QX or G0127-QX

11730:

Many states have an LMRP dedicated to CPT 11730. This code is defined as avulsion of nail. Unless a patient is neuropathic, most states now require injectable anesthesia be used in order to qualify for this code. Some states insist the nail be removed under the eponychium while others do not. Some states

have screens of 90 days before they will allow a repeat nail avulsion of the same border, while others do not. If the same toe is treated in less than 90 days, but a different border is involved, the claim will be denied and then must be appealed for payment.

There are specific documentation requirements and I will suggest a few:

S: Pt presents to office c/o left hallux nail painful x 3 weeks. Patient has had similar previous problem and has refused matrix surgery.
O: Red, warm and painful incurvated tibial left hallux nail border. No cellulitis proximal to IPJ. DP and PT pulses 2/4 B.L.
A: Ingrown nail left hallux tibial recurrent
P: Recommend P and A and pt declines. Three cc 2 % Xylocaine injected base left hallux. Betadine prep. Avulse entire tibial left hallux nail border under eponychium with nail nipper, 62 blade and stat. Cleanse and dress with Betadine solution DSD. Tylenol for pain. Written and oral instructions provide for soaking in dilute Betadine and same topical. Follow up in 3 days, sooner if worse.

This note should hold up in an audit.

CPT 99202:

Please refer to last month's article on this topic for a detailed discussion on this code, but these are three key points:

1. CPT 99202 always requires a chief complaint, at least one to three elements of the history of present illness and at least one system reviewed.
2. CPT 99202 requires an expanded problem-focused exam defined as limited exam of the affected extremity and other symptomatic or related extremities (1195 rules) or 6 bullets using the multi-system exam in the 1997 rules.
3. Decision-making is straight-forward – the lowest level there is. There are no requirements for this level.

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