If you can’t afford a doctor, go to the airport - you will get a free x-ray and a breast exam. If you mention Al Qaeda, you will also get a free colonoscopy.

The opinions given are not necessarily the opinion of the AAPPM and are subject to interpretation by each individual. It is not a substitute for professional legal, financial or medical advice—coding rules and payment policies can differ from carrier to carrier.

I will just put any modifier on the claim to get paid.
I will just guess at what code to use, as long as I get paid who cares, I just let my biller figure it out.

Medicare: YOU are held to the standard of knowing what codes qualify

Why do I need to know Coding

Understanding Coding takes sometime
If we bill wrong, claims get rejected,
Patients will get billed instead
Patients will be unhappy
We have violated Medicare’s rules by billing improperly

The Basics of Coding

The most Dangerous Words

The Beginning

• Get the right tools
• www.Cms.hhs.gov
• Local carriers website:
  – Local medical review policies
• APMA Resource center
  www.apmacodingrc.org
• Coding seminars AAPPM & APMA – know the sources of information
CCI Edits – correct coding initiative

- Created to stop un-bundling of CPT codes
- If you perform a procedure additional procedures may be considered part of the first procedures payment; bunionectomy and associated capsulotomy

- What procedures are bundled together?
- How can you over-ride the CCI edit?
- What should not be bundled – routine foot care/mycotic nails

Dx associated with CPT code

Medicare Guidelines by state
The Basics

• Understand the language
• Claim – a record sent to the ins co that request payment
• Diagnostic Code (ICD Code) – a universal series of numbers that are assigned to a condition/pathology/illness
• Procedure Code (CPT Code) – universal series of numbers that are assigned to a procedure (service)
• Place of Service – where is the service taking place

The Basics – The 4 Keys

• Modifier – a number or code that tells the ins co. more info about what you did (added to the procedure code)
• Global Period – An amount of time that restricts post operative care billing until that time has expired
• CCI edit – Correct Coding Initiative, a system used by Medicare that prevents billing different procedures on the same day that may be related to each other
• Medical Review Policies – policies created by Medicare that govern how procedures may be billed

Why POS matters

• Using the wrong place-of-service code triggers overpayments because Medicare Part B pays more for certain physician services when they are provided at offices or freestanding clinics rather than at hospital departments, including provider-based entities. The reason: professional fees include overhead when services are provided at practices and freestanding clinics. But Medicare Part B reduces professional fees when physicians treat patients in outpatient departments.
Billing Claims

- To construct a claim, assemble the 3 parts – DX, TX, Modifier
- Decide on what Dx you are using
- Decide on what procedure TX you are doing
- LINK, LINK, LINK, LINK
- DX: Ingrown Nail 7030
- TX: Perm nail avulsion 11750

What else??
The 3rd part - the Modifier

- What about a modifier (Modifier – a number or code that tells the ins co. more info about what you did (added to the procedure code
- There are Modifiers for E/M (office visits), for toes, for foot, for routine foot care, for special circumstances (CCI edits), for global periods, for staged procedures, for chocolate.....

Modifiers for E/M visits ONLY

- 24 & 25
  - E/M modifiers – only used here ) 99201-99204, 99202-99214
  - 25 placed only on 99xxx codes, signifies a separate identifiable evaluation other than treatment on that day (office visit with mycotic nails)
  - 24 Unrelated office visit during post op period

Modifiers for Procedures

- 59 Distinct Procedure Service (separate procedure) two procedures done on same day only used to override CCI edit
  - (11730 and 11721 together)
  - 79 Unrelated procedure during a post op period (global period) (ingrown nail during post op treatment of bunion)

Hospice

- GW or GV
- GV - Attending physician not employed or paid under agreement by the patient’s hospice provider.
- GW - Service not related to the hospice patient’s terminal condition.

Toe Modifiers, If you do it to a toe you need a toe modifier!

- Toes, Toes, Toes
  - TA = 1st left
  - T1 = 2nd left
  - T2 = 3rd left
  - T3 = 4th left
  - T4 = 5th left
  - T5 = 1st right
  - T6 = 2nd right
  - T7 = 3rd right
  - T8 = 4th right
  - T9 = 5th right
  - LT = Left
  - RT = Right
Modifiers for Routine Foot Care at Risk Foot Care

- Routine foot care, the cutting and debridement of corns and callouses
- MODIFIERS – Q7, Q8, Q9
- Correspond to clinical findings
- 11055, 11056, 11057 must have one of these!

Special Medicare Review Policy regulations

- 11721 & 11055/7 can only billed every 61 days
- 11730 can only be done 2 times every 60 days
- 11730 is first toe, 11732 is second
- 17110 (lesions 1-14)
- 17111 (lesions 15 and more) stand alone code
- 73630 x-rays only get LT or RT always!

When doing 2 procedures on the same day, you need to understand CCI edits – do you need a 59?

- DX: 7030 TX 11750 TA
- DX: 1101 TX 11721 59
- DX: 7030 TX 11730 TA
- DX: 1101 TX 11721 59

Patient comes back in 2 days after an I&D infection, for thick painful mycotic nails

- Global Periods – are you restricted
- 10, 30, 60, 90 days usual global periods
- Modifier to over-ride saying this treatment has nothing to do with the treatment of the other day ‘79’ only if the previous procedures had a global period
- 10 days: 10060/1, 11750, 17110/1 10days
- Bunion Surgery: 90 days post surgery
- COMPUTER FREE CARE

Foot X-rays:

- 73620 (#22), 73630 (#6), 73650

  - 73620: 2 views foot $21.08
  - 73630: 3 views foot $24.36
  - 73650: 2 views calcaneus $21.84

Nail Procedure codes

- Some Of The Most Audited Codes In Podiatry
11730 (#4), 11732 (#18), 11750, 11765

• 11730- Avulsion of nail plate, partial or complete, simple; single
• 11732- Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
• Involves separation and removal of the entire nail plate or a portion of nail plate (including the entire length of the nail border to and under the eponychium)
  – A nail avulsion usually requires injected local anesthesia except in instances wherein the digit is devoid of sensation or there are other extenuating circumstances for which injectable anesthesia is not required or is medically contraindicated
  – Regrowth of the nail and recurrence of ingrowth will require four months

11730 (#4), 11732 (#18), 11750, 11765

Documentation Requirements

• The patient’s primary symptoms and previous treatment (if any) and description of the nail(s) at the time of avulsion services
• A complete detailed description of the procedure performed including exact portion of nail removed
• Post-operative instructions and any follow-up care
  – such as use of soaks, proper shoes and nail care, to prevent recurrences, antibiotics and follow-up appointments

10060 (#16) And 10061

• 10060- Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
• 10061- Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

26010 and 26011

• 26010- Incision and drainage of finger abscess; simple or single ($198.05
• 26011- Incision and drainage of finger abscess; complicated or multiple ($297.04

Don’t forget to use your finger modifiers (FA-F9)

29580 (#25) vs. 29581

• 29580- Application of an UNNA Boot ($39.97)
• 29581- Application of a multi-layer compression system; leg (below knee), including ankle and foot ($45.62)
Wound cautery

• 17250: Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)

• Silver Nitrate

Pop quiz

• CMS requires doctors to retain their medical records for how long a period of time?

• Forever, since they don’t care about the cost of storage

• 5 years from the date of service

• 6 years from the date of service

• 7 years from the date of service

• 10 years from the date of service if the patient is a Medicare managed care program

Injection Codes

• 20600 - Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)

• 20605 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., ankle)

***Not used for plantar fasciitis***

20600 (#11) vs. 20605 (#19)

• 20600 - Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)

• 20605 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., ankle)

***Not used for plantar fasciitis***

20550 Vs. 20551

• 20550 - Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")

• 20551 - Injection(s); single tendon origin/insertion

Neuroma injection

• 64455: Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton’s neuroma)

• 64450: Injection, anesthetic agent; other peripheral nerve or branch – not for neuroma
**Needle aspiration – fluid, ganglion**
- 10021: Fine Needle aspiration without imaging ($112)
- 10022: Fine Needle aspiration when performed with imaging guidance

**J-Codes**
- J1020- Methylprednisolone acetate 20mg- $3.12
- J1030- Methylprednisolone acetate 40 mg- $3.10
- J1094- Dexamethasone acetate 1mg- $0.23
- J1100- Dexamethasone sodium phosphate 1mg- $0.11
- J3301- Triamcinolone acetonide 10mg- $1.69
- J3303- Triamcinolone hexacetonide per 5mg- $1.68

**How To Appropriately Bill J Codes By Units**
- **Example#1:** J1100- Dexamethasone, 1 mg
  - Your bottle says 4 mg/ml
    - If you use 0.25 cc (1 mg) = 1 Unit
    - If you use 0.5 cc (2 mg) = 2 Units
    - If you use 0.75 cc (3 mg) = 3 Units
    - If you use 1.0 cc (4 mg) = 4 Units

- **Example#2:** J1030 Methylprednisolone Acetate, 40 mg (Depo-Medrol)
  - Your bottle says 40 mg/ml
    - If you use 0.25 cc 10 mg = 1 Unit
    - If you use 0.5 cc 20 mg = 1 Unit
    - If you use 0.75 cc 30 mg = 1 Unit
    - If you use 1.0 cc 40 mg = 1 Unit
    - If you use 2.0 cc 80 mg = 2 Units

- **Example#3:** J3301 Triamcinolone Acetonide, (Kenalog-10, Kenalog-40) per 10 mg
  - Your bottle says Kenalog 40 =40mg/ml
    - If you use 0.25 cc 10 mg/40 mg = 1 Unit
    - If you use 0.5 cc 20 mg/40 mg = 2 Units
    - If you use 0.75 cc 30 mg/40 mg = 3 Units
    - If you use 1.0 cc 40 mg/40 mg = 4 Units

- **Example#4:** J0702 Betamethasone Acetate and Betamethasone Phosphate, per 3 mg (Celestone Soluspan 6 mg/ml)
  - If you use 0.25 cc 1.5 mg/6 mg = 1 Unit
  - If you use 0.5 cc 3 mg/6 mg = 1 Unit
  - If you use 0.75 cc 4.5 mg/6 mg = 1 Unit
  - If you use 1.0 cc 6 mg/6 mg = 2 Units
10140 And 10160

- 10140 - Incision and drainage of hematoma, seroma or fluid collection
- 10160 - Puncture aspiration of abscess, hematoma, bulla, or cyst

Biopsy

- 11100: Cutaneous Biopsies – punch
- Single lesion
- 11101: Cutaneous each additional biopsy add on code

Haglunds Deformation

- 28118: Osteotomy, calcaneus (includes retrocalcaneal bursa removal and exposure of achilles
- 28200: repair, tendon flexor foot without free graft (if other work is done on achilles other than exposure – debridement of necrotic tissue
- Add this code

Pop QUIZ

- When performing a Subtalar Arthroereisis (Screw thingy) which would be the correct way to code for this procedure:
- 28725 Subtalar arthrodesis
- 28585 open treatment of talotarsal joint dislocation
- 28899 unlisted
- S2117 temporary code

Smoking Cessation - 99406

- Diagnosis codes
  - V15.82: History of tobacco use
  - 305.1: Tobacco use disorder
- Smoking Cessation

- 99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- $10.28/$8.77
- Can bill this 2 times/year

Smoking Cessation - 99406

- "I advised the patient to stop smoking as tobacco/nicotine use can cause delays in skin healing, wound healing, surgical healing, tendon and ligament healing, bone healing, can cause skin graft/skin graft substitute failure and can cause problems with his/her circulation. The patient relates that he/she understands all that was discussed."
- $10.28/$8.77
- Can bill this 2 times/year
Care plan oversight (cpo):
How much money are you leaving on the table?

- G0180: Certification: Physician services for initial certification of home health services, billable, once for a patient's home health certification period
  - This code will be utilized when the patient has not received Medicare-covered home health services for at least 60 days
- G0179: Re-Certification: Physician services for re-certification of home health services, billable once for a patient's home health certification period
  - This code will be utilized after a patient has received home health services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period

Orthotics Codes

- L3000: Foot insert, removable, molded to patient model, UC S type, Berkeley shell, each
  - L3000 RT...........$x
  - L3000 LT...........$x
- L3020: Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each
- 29799: Casting -LT $75 - $100
- 29799: Casting -RT $75 - $100
- S0395: (Aetna/Cigna): Impression casting of a foot performed by a practitioner other than manufacturer of the orthotic
- 99002: Handling, mailing, packaging $10
- A4580: Material plaster $40

E&M Add-On Codes - Billed In Addition To Your E&M Codes

- 99050: Services provided in the office at time other than regularly scheduled office hours or when the office is usually closed (in addition to the basic service) ~$25.00
- 99051: Services provided in the office during regularly scheduled evening, weekend, or holiday hours (in addition to the basic service) ~$25.00

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- "Failure is not in the falling down but in the staying down" - Unknown Author

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