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.

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.

* 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

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**CODING POP QUIZ**

1. 11730 TA, 59  11721, 59
2. 11730 59, 11721, 59
3. 11730 TA  11721
4. 11730 TA, RT  11721
5. 11730 RT  11721 59
6. trick question all are wrong, should not bill these together
7. I don’t worry about modifiers that’s my billers job
BEGIN WITH THE CORRECT TOOLS

www.apmacodingrc.org
Recommended by the AAPM

www. (your medicare carriers website)

ADVANCE CODE SEARCH

CCI EDIT TABLE

DX ASSOCIATED WITH CPT CODE

MEDICARE GUIDELINES BY STATE
DME GUIDELINES BY STATE

WHAT ABOUT ICD 10?
- APMAcodingRC.org has you covered
- Cross Walks and more

DIAGNOSIS YOU SHOULD CONSIDER

Systemic disease is part of your grading scale
Are you worth the money?
110.1, 25000, 4439 more than just the numbers....

PART B NATIONAL SUMMARY DATA
- Formerly known as BESS (Part B Extract Summary System)
- Data BMAD DATA
- How Medicare tracks the most commonly billed CPT Codes
  - Available for all medical specialties
  - The most up-to-date data that we currently have is 2011
  - Top 25 Billable Codes for Podiatry

PART B NATIONAL SUMMARY DATA - TOP 25 BILLABLE PODIATRY CODES

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<td>99203</td>
<td>18.11732</td>
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</tr>
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</table>
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

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
- 11750- Excision of the nail and the nail matrix performed under local anesthesia requiring 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) followed by destruction or permanent removal of the associated nail matrix
- 11765- Wedge excision of the nail fold hypertrophic granulation tissue with removal of the offending portion of the nail

11730 (#4), 11732 (#18), 11750, 11765
- 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 (#11)**: Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)
- **20605 (#19)**: Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., ankle)

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

- J1020: Methylprednisolone acetate 20mg - $3.12
- J1030: Methylprednisolone acetate 40mg - $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
- J9040: Bleomycin
  - Billed out at 15 units - $28.58 per unit ($428.70)

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

HOW TO APPROPRIATELY BILL J CODES
BY 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
HOW TO APPROPRIATELY BILL J CODES BY 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
- 11101: Cutaneous each additional biopsy add on code

HAGLUNDS DEFORMITY

- 28118: Ostectomy, 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
Diagnosis codes
- V15.82: History of tobacco use
- 305.1: Tobacco use disorder

SMOKING CESSATION - 99406

99406: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

“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

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 beyond 9 to 5 (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

ORTHOTICS CODES TO CONSIDER

L3000: Foot insert, removable, molded to patient model, UCB 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
50396: (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

As of June 11, 2012, a Coding Clarification was made by Jurisdiction B DME in regards to Toe Fillers and Diabetic Shoe Inserts
Questions have arisen about the correct coding for shoe inserts used to accommodate missing digits (toes) on feet for beneficiaries with and without diabetes. These items fall under two separate benefit categories and use two distinct Healthcare Common Procedure Coding System (HCPCS) codes, L5000 and A5513.

**BENEFICIARIES WITHOUT DIABETES**

Shoe inserts for beneficiaries with missing toes or partial foot amputations who are not diabetic are considered for coverage under the prosthetic benefit. **Code L5000** is described by:

- **L5000**: Partial foot, shoe insert with longitudinal arch, toe filler

Additional soft material is added where contact is made with the residual limb/toes. For beneficiaries missing digits, particularly the hallux (great toe), or the forefoot, L5000 inserts are designed to provide standing balance and toe off support for improved gait. The biomechanical control required of L5000 differs from the foot-protective function provided by inserts used as part of diabetes management.

**BENEFICIARIES WITH DIABETES**

A separate benefit category allows Medicare coverage of therapeutic shoes and inserts for persons with diabetes. Shoe inserts for persons with diabetes are described by the codes below:

- **A5512**: For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each

- **A5513**: For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each
MATH PROBLEM

John has 32 candy bars, He eats 28, what does he have now?

Diabetes

DEBRIDEMENT CODES

Not Including Subq
- 97597 debridement not including subq < 20 sq (first 20 sq)
- 97598 debridement not including subq > 20 sq (each additional)
You can bill these together 97597 & 97598

Including Subq
- 11042 debridement includes subq < 20 sq
  11045 added if > 20 sq
- 11043 includes subq/muscle/fascia < 20 sq
  11046 added if > 20 sq
- 11044 includes subq/muscle/bone < 20 sq
  11047 added if > 20 sq

POP QUIZ

- A Medicare patient fails to show for their scheduled appointment, knowing that there is a cost associated with the time left blank by the patient not showing, which is true:
  - Billing Medicare for the no show would be inappropriate
  - Medicare does not allow billing the patient for the no show
  - Medicare requires billing for the no show and after a rejection will allow the patient to be billed
  - Medicare doesn’t run our office or pay the overhead, so we bill what we deem correct
  - Medicare allows billing the patient for the no show

JUST AS IMPORTANT AS THE CODES...
MODIFIERS AND OTHER BILLING INDICATORS

WHAT ARE MODIFIERS FOR?

- They provide more information on your claim and increase your chance for reimbursement

PLACE OF SERVICE CODES

- 11 – Office
- 12 – Home (Be sure to use for CMS DME !!)
- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Room Hospital
- 24 – ASC
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility
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.

### TOE MODIFIERS, IF YOU DO IT TO A TOE YOU NEED A TOE MODIFIER!

- Toes, Toes, Toes
  - TA = 1st left
  - T6 = 1st right
  - T1 = 2nd left
  - T7 = 2nd right
  - T2 = 3rd left
  - T8 = 3rd right
  - T3 = 4th left
  - T9 = 4th right
  - T4 = 5th left
  - T10 = 5th right

LT = Left
RT = Right

### EVALUATION AND MANAGEMENT MODIFIERS

These Modifiers are only used on E/M codes: 99xxx

### 24

- **24** Unrelated E/M Service During a post operative visit
  
  During a post operative visit (within the global period), the patient presents with an acute onset of heel pain
  
  99213 - 24

### 25

- **25** Significantly separately identifiable Evaluation and Management service by the same physician on the same day as the procedure or other service

  During a visit for heel pain which requires an injection, the patient also presents with an ingrown nail
  
  99213 - 25 (703.0)(728.71)
  
  20550 (728.71) RT

### SURGICAL MODIFIERS
A procedure or service that was distinct or independent from other services performed on the same day

During a first metatarsal head osteotomy, the surgeon also corrects a hammer toe deformity

28296 (735.0) RT
28285 (735.4) -RT, 59

79 Unrelated surgery during postop period

At the first post operative visit following a bunion surgery, the patient presents with an ingrown nail requiring an I/D

99213 (703.0), 681.10) - 24
10060 (681.10) – 79 TA

ADVANCED BENEFICIARY NOTICES

Waiver of liability statement on file

Use to indicate that the physician’s office has a signed advance notice retained in the patient’s medical record. The notice is for services that may be denied by Medicare.

A patient presents for at risk foot care sooner than what is normally allowed

GA

Waiver of liability statement NOT on file

Use to indicate when an item or service is statutorily excluded or does not meet the definition of any Medicare benefit.

A patient presents for foot care without qualifying findings

GET PAID FOR YOUR HOSPICE PATIENTS!
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.

DME RELATED MODIFIERS

- KX
  - The KX modifier is added to claims for equipment that require a certificate of medical necessity (CMN) or that currently require a written order prior to delivery (WOPD).

A FREQUENTLY “MISSED” OPPORTUNITY MODIFIER 76

- 76: Repeat procedure by same physician – The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service.

  Repeat xray for manipulation of dislocation
  Return to OR same day, implant dislocation

NOTHING STAYS THE SAME

Even if you’re on the right track, you’ll get run over if you just sit there.
Will Rogers

ICD 10 in 2014

Jfrederick@aappm.org
Coding and Billing seminar
November 30, 2012 Arizona

ROUTINE FOOT CARE – AT RISK FOOT CARE

Up Next

- How to bill correctly AT RISK FOOT CARE