eGlobalTech

CBR201608:
Podiatry-Nail Debridement and Evaluation and Management Services

Webinar Questions and Answers

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INTRODUCTION

These questions are excerpted from the CBR201608: Nail Debridement and Evaluation and Management (E/M) Services webinar presented on Wednesday, June 22, 2016. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version, or view the webinar text. You may also open a PDF of the slides only or select a specific section of the webinar. All of these options are available from the CBR website page titled, CBR201608 Webinar Information (http://www.cbrinfo.net/cbr201608webinar.html?wb48617274=B4CEE8C4).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled, Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&P=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAA%3d%3d&=). Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

GENERAL

Q. What is a Comparative Billing Report (CBR)?
A. A Comparative Billing Report (CBR) provides data on how an individual health care provider compares to other peer providers in their state and nation. CBRS help the Centers for Medicare & Medicaid Services (CMS) address potential over-utilization in the Medicare Fee-for-Service (FFS) program. The goal of these reports is to offer a tool that helps providers better
understand applicable Medicare billing rules and improve the level of care they provide to their Medicare patients. To view a copy of the Sample CBR, select the web link titled, **CBR201608 Sample CBR** (http://www.cbrinfo.net/cbr201608-sample-cbr.html).

**Q. Will this be a live, interactive webinar?**
A. Attendees can listen to our live presentation on a computer, iPad, or Android tablet via the AnyMeeting webinar service we use to host our presentations. During the Question and Answer session, attendees will be able to submit questions using the chat function. Any questions related to the information presented that we are not able to respond to during the webinar will be addressed in a detailed Q&A document, which will be posted to our website with a handout of the presentation. Those documents will be available within 14 days of the webinar held on June 22, 2016. Anyone who was unable to attend the live webinar or who would like to listen to the presentation again can download the recording in its entirety, or listen to sections from the following link on the CBR web page: **CBR201608 Webinar** (http://www.cbrinfo.net/cbr201608-webinar.html).

**Q. Are there any continuing education units (CEUs) for participating in today’s webinar?**
A. No. The Centers for Medicare & Medicaid Services (CMS) is not offering CEU credits for attending CBR webinars. Information related to CEU credits is located on the CMS website at the link, **Continuing Education Credit Information** (http://www.cms.gov/Outreach-and-Education/Outreach/NPC/CEC_Notification.html).

**Q. Can I see or get a CBR report/letter sent to my office or email address?**
A. CBRs have already been mailed to all of the podiatry physicians who were selected to receive CBR201608. To ensure privacy, information in each CBR letter is shared only with each individual provider. A sample report has been created for a mock provider that looks like CBR201608 and allows providers who did not receive a CBR the opportunity to read the CBR content, see the references provided in the text, review the statistical methodology, and see the data presented. To view a copy of the Sample CBR, select the web link titled, **CBR201608 Sample CBR** (http://www.cbrinfo.net/cbr201608-sample-cbr.html).

**Q. How can I obtain a copy of the CBR for my providers? Is there a way to obtain specific reports (for example, a regional report within the state)?**
A. The CBR team cannot produce reports on an ad-hoc basis by request; however, percentages and averages were calculated for each provider, for all providers in each state, and for all providers in the nation. Each provider was compared to peer physicians in their state and the nation because we understand that standards of practice and charges may vary by geographic location. To review the percentages of services rendered by each state and the nation, please see the following CBR website link: **CBR201608 Statistical Debriefing** (http://www.cbrinfo.net/cbr201608-statistical-debriefing.html).
**Q. If a provider misses the webinar, can they listen to a recording later?**

A. Yes. The recording will be available on the CBR website within five days of the webinar held on June 22, 2016. Providers who were unable to attend the live event, or who would like to listen to the presentation again, can download the recording in its entirety or by sections, by selecting links located on the CBR website at [CBR201608 Webinar](http://www.cbrinfo.net/cbr201608-webinar.html). The Q&A document and a detailed handout of the webinar will be available on the website within 14 days of the webinar date. Providers may also benefit from the references and resources located on our CBR website at the link titled, [CBR201608 Recommended Links](http://www.cbrinfo.net/cbr201608-recommended-links.html).

**Q. Will the CBRs lead to audits?**

A. A CBR is not an audit or precursor to an audit. Providers will not be audited by the CBR team, as we do not have access to medical records. The sole purpose of the CBR is to allow a provider to compare their billing patterns to those of their peers; however, it may be beneficial for providers to conduct self-audits. For resources that can help with setting up an audit process, please visit our CBR website page at [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).

**Q. How can I contact the CBR Help Desk?**

A. The CBR Support Help Desk is available from 9:00 a.m. to 5:00 p.m. (ET) Monday through Friday, and can be contacted by calling the Toll Free Number at 1-800-771-4430 and by email at cbrsupport@eglobaltech.com.

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**CLINICAL AND BILLING**

**Q. What is pain with ambulation?**

A. To ambulate is to walk about or move from place to place. Experiencing pain with ambulation means that the beneficiary has pain when they walk. In the case of mycotic toenails, the beneficiary has pain because of the thickness and/or length of the toenail plate that is affected. Per the *Medicare Benefit Policy Manual*, “The treatment of mycotic nails for an ambulatory patient is covered only when the physician attending the patient’s mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.” For more information, select the following link: [Medicare Benefit Policy Manual, Chapter 15, Section 290 (C.4)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf).

**Q. How can a registered nurse provide nail care for seniors in an outpatient setting?**

A. A registered nurse who is not a nurse practitioner or clinical nurse specialist cannot bill Medicare for nail care services. “Incident to” billing would also not apply since “incident to”

Q. When can a podiatrist bill using an E/M code and what elements must be either met or exceeded?
A. Podiatrists can bill for E/M services when medical necessity exists for the service. The level of service billed is based on the medical necessity of the visit and the elements required during the visit based on the patient’s chief complaint. For established patients, those who have been seen in the past three years, two of the three key components of history, examination and medical decision making must be met or exceeded. For new patients, all three of the key components must be met or exceeded. When billing for an E/M code and a procedure of some type on the same day, providers should be aware that some procedures have an inherent E/M built into the code, meaning that providers are already being paid for the evaluation necessary to determine the need for and carry out the procedure and provide aftercare. In those cases, an established patient E/M can only be billed if the patient is seen for a problem that is not related to the procedure performed on the same date of service. Providers should also become familiar with global surgical periods and be aware that new patient E/Ms are typically exempted from global surgical rules. To ensure Medicare guidelines are being followed, providers should review the procedures in Chapter I of the NCCI Policy Manual at the link, National Correct Coding Initiative Edits (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html). Additional resources include:


Q. What is the presumption of coverage?
A. According to the MLN Matters® article titled, Foot Care Coverage Guidelines, “When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement.” For more details, select the following web link: Foot Care Coverage Guidelines, SE1113 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1113.pdf). For the purposes of applying this presumption, please refer to the following web link: Medicare Benefit Policy Manual, Chapter 15, Section 290 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf).
Q. When is a referring physician and the last date of service required for the claim to be paid?

A. When the beneficiary has a condition falling under the active care requirement, those conditions with an asterisk beside the ICD-10 code, the patient must be seen by an M.D., D.O. or non-physician practitioner for the treatment and/or evaluation of the complicating disease process during the six-month period prior to the routine foot care procedures. CGS Administrators LCD L31896 lists those diagnoses codes. CGS Administrators LCA A50877 states, “The approximate date when the beneficiary was last seen by the M.D., D.O., or qualified non-physician practitioner who diagnosed the complicating condition (attending physician) must be reported in an 8-digit (MM/DD/YYYY) format in Item 19 of the CMS-1500 claim form or the electronic equivalent.” Chapter 26 of the Medicare Claims Processing Manual covers completing and processing form CMS-1500. Section 10.4 (item 19) instructs providers to enter the date and NPI of the attending physician when a routine foot care claim is submitted. To review the information mentioned, select the below web links:


Q. Can podiatrists bill for prolonged services?

A. Yes. The CMS publication, MLN Matters® provides information regarding this type of billing. To access the article, select the following link: Prolonged Services (Codes 99354 - 99359) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf).

Q. Is CPT® code 11719 payable with CPT® code 11720-XS for a patient with a covered systemic diagnosis (with an asterisk), but without a nail diagnosis for the non-dystrophic nails?

A. According to the National Correct Coding Initiative Edits, this code pair bundles. CPT® code 11719 is in the first column, and CPT® code 11720 is in the second column with a modifier indicator of 1. This means that a modifier can be used to override the bundling edit. If the patient has a covered systemic condition, a modifier can be used to override the edit. According to Wisconsin Physicians Service (WPS) Insurance Corporation, modifier XS should only be used when there is no other modifier to describe the situation. Per the WPS Modifier XS Fact Sheet, “Providers should evaluate other modifiers such as RT/LT identifying right and left, F1-F0 to identify fingers, T1-10 to identify toes and E1-E4 to identify eyelids. Evaluate additional modifiers to determine appropriate usage.” To review more information, visit the WPS website at the link titled, Modifier XS Fact Sheet (http://www.wpsmedicare.com/j5macparta/resources/modifiers/modifier-xs.shtml).
Additional information on modifiers and edits can also be found at the link, National Correct Coding Initiative Edits (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html).

Q. Does the E/M coding pertain to all E/M codes billed by my provider or just those billed with CPT® codes 11721/11720?
A. For this CBR, if a provider billed a debridement service, CPT® codes 11720 or 11721, all of their E/M codes were measured using the metric of average minutes of E/M services per visit, including those E/Ms that were not billed in conjunction with a debridement service. If a provider did not bill for CPT® codes 11720 or 11721, they did not receive a CBR. If you did not receive a CBR and wish to review a sample of a mock provider’s letter, visit the CBR website at the link titled, CBR201608 Sample CBR (http://www.cbrinfo.net/cbr201608-sample-cbr.html).

Q. What is the difference between CPT® code 11721 and G0127?
A. G0127 refers to trimming dystrophic nails. CPT® code 11721 refers to debridement of any type of nail. Trimming is the reduction of the length of the nail, or cutting off the end of the nail that is not attached to the nail bed. A dystrophic nail is a nail which has disease causing dystrophy or bad formation. Dystrophic nails can be discolored, misshapen or brittle. Debridement of a nail is the act of significantly reducing the thickness and possibly length of a toenail that has become thick due to disease. Nails become thick due to various conditions, such as fungal infections.

Q. When should Loss of Protective Sensation (LOPS) Healthcare Common Procedure Coding System (HCPCS) codes G0245, G0246, & G0247 be used versus a “regular” E/M?
A. NCD 70.2.1 is titled, National Coverage Determination (NCD) for Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy). That document states that Medicare will pay for an examination and treatment of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. The LOPS examination includes a patient history, a physical examination with defined elements and patient education. Per NCD 70.2.1, “Treatment includes, but is not limited to:
- Local care of superficial wounds
- Debridement of corns and calluses
- Trimming and debridement of nails.”

For more information, select the following link: NCD 70.2.1 (https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=171&ncdver=1&bc=BAAGAAAAAA). Evaluation and management codes are not payable on the same date of service as G0245, initial LOPS evaluation and G0246, follow-up LOPS examination, according to the National Correct Coding Initiative edits. G0247 describes routine foot care of a patient with LOPS and includes nail debridement, debridement of corns and calluses and wound care. Therefore, CPT® codes 11720, 11721, G0127, 11042,
11055, 11056 and 11057 are not separately payable with HCPCS code G0247. More information on modifiers and edits can be found at the link, National Correct Coding Initiative Edits (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html).

Q. What are Palmetto GBA’s LCDs for nail debridement and routine foot care?
A. Palmetto GBA does not have an active LCD covering nail debridement or routine foot care, as of June 17, 2016.

Q. Is ESRD considered systemic illness?
A. Yes. A systemic disease is one that affects a number of organs and tissues, or affects the body as a whole. According to the Medicare Benefit Policy Manual (Chapter 15 Section 290 – C,D), “The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual’s legs or feet. (See subsection A.)” Per the manual, “Although not intended as a comprehensive list, metabolic, neurologic, and peripheral vascular diseases...most commonly represent the underlying conditions that might justify coverage for routine foot care...Peripheral neuropathies involving the feet – associated with uremia (chronic renal disease).” Conditions listed that are followed by asterisks indicate that the patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. You may also find a list of systemic illnesses at CGS Administrators LCD L34246. To view this information, select the following links:

- CGS Administrators LCD L34246 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34246&ver=5&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11720&bc=gAAAABAAAAAAA%3d%3d&)

Q. If a patient does not qualify for Medicare coverage for nail care; do we still need to bill Medicare or can we just have patient pay for the service?
A. The beneficiary has the option of paying out of pocket. However, if the beneficiary wants you to bill Medicare, then you must issue an Advance Beneficiary Notice (ABN). The ABN is a written notice you must issue to a Fee-for-Service beneficiary before providing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity. The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment, and providers may be financially liable if Medicare does not pay. When submitting the claim, append the GA modifier, which denotes that the supplier/provider has provided an ABN to the
beneficiary. Your MAC will assign beneficiary liability to claims submitted with the GA modifier appended. Additional guidance on the ABN and GA modifier is found in the Medicare Learning Network® publications and the Wisconsin Physician Services (WPS) fact sheet at the links below:

- **Modifier GA Fact Sheet** ([http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier-ga.shtml](http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier-ga.shtml))

**Q. If a provider orders an FDA approved, anti-fungal medication for the treatment of mycosis and the patient refuses to fill the medication due to costs, can nail debridement continue to be covered?**

A. CGS Administrators LCD L34246 states, “Payment may be made for the debridement of a mycotic nail (whether by manual method or by electrical grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit.” The CBR team suggests that you refer this question to your MAC for additional guidance. Please refer to the following link for general information: [CGS Administrators LCD L34246](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34246&ver=5&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11720&bc=gAAAAABAAAAAAA%3d%3d&).

**Q. Do I have to bill for nail service if I cut a patient’s nails during an initial visit?**

A. The choice of whether you file a claim or not is up to the beneficiary. If the patient agrees to personally pay for a service, no claim is required. If the patient requests that a claim be filed but a provider feels that Medicare will not pay for a service because it isn’t medically necessary, the provider should ask the beneficiary to sign an Advanced Beneficiary Notice or ABN. If the beneficiary chooses **Option 1** on the ABN form, this means that the beneficiary wants the provider to file a claim for the service (this affords the patient appeal rights in case of a denial). If the beneficiary chooses **Option 2** on the form, this means they do not want the provider to file a claim, in which case they cannot file an appeal. A provider should append a GA modifier to the procedure code if Medicare is expected to deny the service because it is not medically necessary. Use of this modifier ensures that, upon denial, Medicare will automatically assign the beneficiary liability. A supplemental insurer who pays for these services may require a Medicare claim denial notice prior to making payment. The ABN can be accessed on the CMS website at the following link titled, **FFS ABN** ([https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)). More information about the ABN can also be found in the MLN™ publication at the link titled, **Medicare Advance Beneficiary Notices** ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf)).
Q. Can providers be paid for E/M services when billing for CPT® codes 11720 and 11721?

A. In the case of CPT® codes 11720 and 11721, payment for office E/M services CPT® codes 99201 through 99215 bundle in to the payment for CPT® codes 11720/11721 and are not paid separately according to the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits. Many other E/M service CPT® codes also are not paid separately. However, the modifier indicator is “1,” meaning that an applicable modifier can be used to override the bundling edit when the clinical circumstances support its use. In order to use a modifier (in this case modifier 25), the E/M would have to be separately identifiable from the nail care service. However, the trimming, cutting, clipping, and/or debriding of nails are usually considered routine and may not covered by Medicare. In order for routine foot care to be covered, the patient’s medical record must support the diagnoses and procedures submitted as well as the medical necessity of the services. For additional guidance, select the following Medicare Learning Network® publication link: Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicarePodiatryServicesSE_FactSheet.pdf).

Q. Does performing many quality measures (including BMI screening, blood pressure screening, alcohol assessment and tobacco use assessment, etc.) on our nail care patients by participating in the physician quality report system (PQRS) justify billing an E/M along with nail care services?

A. No. Reporting quality measures does not warrant billing an E/M service. Because the face-to-face visit is represented by other codes (in this case nail care CPT® codes 11720 and 11721), an additional E/M billed would have to satisfy the requirements for appending modifier 25 for a significant, separately identifiable E/M service. According to Chapter 12 of the Medicare Claims Processing Manual (Section 30.6.1), “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.” Medical necessity should guide the care. Even if an E/M service is performed, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter, as documented, can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted. An E/M service would need to be separate and significantly identifiable and medically necessary. For more detailed information, select the following link: Medicare Claims Processing Manual (Section 30.6.1) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf).
Q. How much limitation of ambulation is necessary to be considered "marked" limitation of ambulation?
A. The medical record should support that ambulation is limited enough to interfere with activities of daily living. Limitation of ambulation could not be used to support medical necessity if the beneficiary was chair or bed confined. The record should contain a description of the severity of the specified condition not just mention that the particular condition is present. Simply stating “limited ambulation” would not be sufficient. More information is available at this link: Novitas LCD L35013 [Link](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35013&ver=10&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAABAAAAAAA%3d%3d&).

Q. Is documentation of pain in the toenails sufficient to meet the LCD and medical necessity requirements?
A. Pain alone is insufficient to warrant routine foot care. Medicare payment may be made for routine foot care when the patient has a systemic condition that would put the patient at risk of injury if the care was performed by a non-professional. The presence of a systemic condition and mycotic nails may indicate medical necessity and justify coverage. Please refer to the following links and your MACs LCD for further guidance:


Q. If documenting pain in the toes or difficulty ambulating is not sufficient to support billing that as a secondary diagnosis, what would the appropriate documentation be?
A. The patient’s medical record must support the diagnoses and procedures submitted, as well as the medical necessity of the services. Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that there is clinical evidence of mycosis of the toenail and the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a non-ambulatory patient is covered only when the attending physician documents in the medical record that there is clinical evidence of mycosis of the toenail and the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. The record should contain a description of the severity of the specified condition not just mention that the particular condition is present. Simply stating “painful nail,” “limited ambulation” or “infection” would not be sufficient. For more information, please refer to the MLN Matters® documentation guidelines at the following web link: for more information: [Foot Care Coverage Guidelines](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/SE1113.pdf).
Q. Does an MD need to document thickness of nails when nails are mycotic?
A. According to Novitas LCD L30513, “For each service encounter, the medical record should contain the number of nails debrided and a description of each nail, which requires debridement. This should include, but is not limited to, the size (including thickness) and color of each affected nail.” Novitas LCD L35013 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35013&ver=10&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAAABAAAAAAA%3d%3d&).

Q. What are the criteria for payment of fungal infection (e.g., recurrent infection)?
According to National Government Services (NGS) LCD L33636, “Payment may be made for the debridement of a mycotic nail (whether by manual method or by electric grinder) when definitive antifungal treatment options have been reviewed and discussed with the patient at the initial visit.” Novitas Solutions LCD L35013 states, “Definitive treatment of mycotic nails involves the appropriate use of effective antifungal pharmacological agents with or without periodic debridement of dystrophic nail plates to lessen the fungal load. Medicare will cover debridement of mycotic nails as an adjunct to pharmacologic treatment...Confirmation of mycotic nail infections by laboratory tests such as fungal cultures and/or stains is not necessary for Medicare coverage of debridement when clinical findings are strongly supportive of the diagnosis and treatment is not contraindicated. Mycological confirmation by culture, potassium hydroxide examination, or dermatophyte testing to differentiate fungal disease from other nail pathology may be required for Medicare payment of mycotic nail debridement in some circumstances such as previous unsatisfactory treatment results (recurrent nail disease, unsuccessful treatment with FDA approved antifungal medications, long term - beyond 12 debridements per 24 months, etc.) and for patients whose debridement is prescribed absent of concomitant pharmacologic therapy, such as for patients deemed to be too high risk for oral antifungal medication use.” To review more details, see the web links below:


Q. What are the requirements for podiatrists to bill just CPT® code 11721?
A. Medicare payment generally may be made for mycotic nail debridement in one of two circumstances. The patient’s medical record must support the diagnoses and procedures submitted, as well as the medical necessity of the services. Treatment of mycotic nails for an ambulatory patient is covered only when the physician attending a patient’s mycotic condition documents in the medical record that there is clinical evidence of mycosis of the toenail and the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Treatment of mycotic nails for a non-
ambulatory patient is covered only when the physician attending a patient’s mycotic condition documents in the medical record that there is clinical evidence of mycosis of the toenail and the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Nail debridement may also be covered if the patient has a diagnosis of mycotic toenails and certain systemic conditions. A list can be found in the Medicare Benefit Policy Manual Chapter 15, Section 290. It is not intended to be a comprehensive list. For detailed information, see the following web link: Medicare Benefit Policy Manual (Section 290) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Q. Can CPT® code 11721 be used for a thick nail that needs debridement that is NOT mycotic?
A. It depends on the necessity of the debridement service. The presence of a systemic condition, such as metabolic, neurologic, or peripheral vascular disease, may require specialized foot care by a professional that (in the absence of such condition) would be considered routine (and, therefore, excluded from coverage). Accordingly, routine foot care may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the patient’s legs or feet. In these instances, certain foot care procedures that are otherwise considered routine (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a non-professional on patients with such systemic conditions. NGS LCD L33636 states, “In addition, procedures for treating toenails are covered for the following: Onychogryphosis (defined as long-standing thickening, in which typically a curved hooked nail (ram’s horn nail) occurs), and there is marked limitation of ambulation, pain, and/or secondary infection where the nail plate is causing symptomatic indentation of or minor laceration of the affected distal toe; and/or Onychauxis (defined as a thickening (hypertrophy) of the base of the nail/nail bed) and there is marked limitation of ambulation, pain, and/or secondary infection that causes symptoms.” The following web link provides more information: NGS LCD L33636 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33636&ver=30&CoverageSelection=Local&ArticleType=All&PolicyType=Final&ss=All&CptHcpcsCode=11721&bc=gAAAAABAAAAAAA%3d%3d&).

Q. Do you have to document peripheral vascular disease with CPT® codes 11720 11721 or is diabetes with the Q modifier sufficient (because I was told the patient has to have a diagnosis of vascular disease)?
A. Per NGS LCD L33636, the patient does not have to have vascular impairment. Group 3 codes include CPT® codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127. If the beneficiary has a diagnosis in the group 3 code diagnoses table (such as diabetes mellitus with diabetic mononeuropathy), class finding modifiers are not required because the diagnoses code provides evidence that the beneficiary has neuropathy, but no vascular impairment. Foot care services are covered in the presence of a systemic condition based on the list of illnesses described in Chapter 15 (Section 290) of the Medicare Benefit Policy Manual. National modifiers were established to allow the class findings to be reported without writing a narrative
description when debridement of nails is required due to a systemic condition. The claim must include the diagnosis code of covered indication, the systemic condition diagnosis code, the class finding with modifier Q7, Q8, or Q9 and the name and NPI of referring/ordering physician actively treating the patient's condition as well as the date last seen. To review detailed information, select the following links:

- [NGS LCD L33636](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33636&ver=30&CoverageSelection=Local&ArticleType=All&Poi polyType=Final&s=All&CptHcpcsCode=11721&bc=pAAAAABAAAAAAA%3d%3d&)

Q. If you bill for an E/M and debridement and no separately identifiable issue besides the debridement was addressed, is that incorrect and will the provider be “dinged” for it?

A. It is inappropriate and incorrect to report an E/M code when routine foot care or a nail trimming/debridement service is the only service the beneficiary required. In the Medicare Learning Network® publication titled, *Avoiding Medicare Fraud and abuse: A Roadmap for Physicians*, it states, “When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying that you earned the payment requested and complied with the billing requirements. Examples of improper claims include: billing for services that you did not actually render; billing for services that were not medically necessary; billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.” It goes on to state, “An example of upcoding related to E/M codes is the misuse of modifier -25. Modifier -25 allows additional payment for a separate E/M service rendered on the same day as a procedure. Upcoding occurs if a provider uses modifier -25 to claim payment for an E/M service when the patient care rendered was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.” For pertinent information about billing, see the below links:

- [Avoiding Medicare Fraud and abuse: A Roadmap for Physicians](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FraudA_Physicians_FactSheet_905645.pdf)

Q. Can you give an example of "correct" billing of an E/M with CPT® code 11721 (e.g., if the patient complains of heel pain on same day as CPT® code 11721 is being billed - specifically regarding billing CPT® codes 99213 and 11721)?

A. It would depend on the work involved in order to evaluate and treat the heel pain. Heel pain would be a different complaint. In order to bill for CPT® 99213, two out of the three key components must be met: Either an expanded problem focused history; an expanded problem focused physical exam or low complexity medical decision making. The documentation should
support that the service performed was significant and separately identifiable for the nail debridement. According to the American College of Physicians' ACP Internist® article, Learn Proper Coding for Modifiers 59 and 25, documentation must be extensive enough that the additional service is readily identifiable to auditors who might review the claim. The article states, "The E/M service must require additional history, exam, knowledge, skill, work time and/or risk above and beyond what is usually required for the procedure, and these must be included in the documentation." To read the entire ACP Internist® article, select the following link: Learn Proper Coding for Modifiers 59 and 25 (http://www.acpinternist.org/archives/2012/07/coding.htm?wb48617274=3E1AFF86).

**Q. If the physician documents "debridement of all nails," is this sufficient to support billing code 11721?**

A. No. First Coast Service Options (FCSO) LCD L33922 states, “The provider of the service(s) must document the affected nail(s), including the clinical evidence of mycosis, and the manner in which and to what extent the nail(s) were debrided. Use of appropriate anti-fungal treatment or the contraindication of such treatment must also be documented. In addition, a description of the qualifying symptoms for debridement of toenail(s) must be documented.” Documentation should be sufficient to substantiate the services provided. Audit examples of CPT® code 11721 have included beneficiaries with only one foot. Complete details can be found at the link titled, FCSO LCD L33922 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33922&ver=3&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAAABAAAAAAA%3d%3d&).

**Q. If CPT® code 11721 is used, can the remaining nails be considered under non-covered services?**

A. In this situation there are no non-covered services because CPT® 11721 reimburses you for debridement of 6 or more toenails. The CPT Manual® can provide more information on coding and can be accessed from the American Medical Association (AMA) website at the link: AMA Store (https://commerce.ama assn.org/store/catalog/subCategoryDetail.jsp?category_id=cat1150007&navAction=push).

**Q. Our contractor states we have to use the G0127 if there is also a callus debridement (11055, etc.) - we are not allowed to use CPT® codes 11055 and 11720 (or 11721) together. If the definition is different, how are we supposed to correctly use the procedure codes?**

A. As long as the callus or corn is not on a toe that has been debrided, both codes should be payable but a modifier would need to be submitted, as well as correct diagnoses codes. When you look up the code pairs in the National Correct Coding Initiative Procedure to Procedure (PTP) Edit tables, CPT® code 11055 is in the left column and CPT® codes 11720 and 11721 are in the right column. The modifier indicator is “1.” This means an appropriate modifier is allowed to over-ride this pairing when the clinical indication is supported. One of the following modifiers that is appropriate to indicate which nails were debrided should be used: LT, RT, or...
T1- T9. The modifier is added to the code that is normally not paid, in this case CPT® code 11720 or 11721. To find the reimbursable code of a PTP code pair in the Practitioner PTP Edits tables, please select the following link: PTP Coding Edits (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

Q. If patient has a complaint of painful feet and the podiatrist performs nail debridement but also notes that the patient has edema and other skin changes in addition to the infected toenails, would that be an example of when use of modifier 25 is appropriate?

A. Not in every case. Simply noting the patient has edema and other skin changes does not support an additional E/M service. According to NGS LCD L33636, the patient’s medical record must contain documentation that fully supports the medical necessity for services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. According to the American College of Physicians’ ACP Internist® article, Learn Proper Coding for Modifiers 59 and 25, documentation must be extensive enough that the additional service is readily identifiable to auditors who might review the claim. The article states, “The E/M service must require additional history, exam, knowledge, skill, work time and/or risk above and beyond what is usually required for the procedure, and these must be included in the documentation.” The links below will provide more information about documentation requirements:

- Learn Proper Coding for Modifiers 59 and 25 (http://www.acpinternist.org/archives/2012/07/coding.htm?wb48617274=3E1AFF86)

Q. Please clarify the active care requirement. Is it a 30-day or six-month period after the date last seen by the MD? We thought 30 days had been removed and that we can only use six months previous.

A. Thank you for bringing this to our attention. You are correct. After further research, we found that our information about the 30-day period was not from the most current edition of the Medicare Benefit Policy Manual. The correct guidance from Chapter 15 (Section 290) of the Medicare Benefit Policy Manual (revised 03-11-16) states, “For purposes of applying the coverage presumption where the routine services have been rendered by a podiatrist, the contractor may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the 6-month period prior to the rendition of the routine-type services.” Please review the guidelines at the link titled, Medicare Benefit Policy Manual, Chapter 15 (Section 290) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).
**Q. If a provider addresses diabetic foot care and then performs nail debridement, does the diabetic foot exam support billing a separate E/M?**

A. No. HCPCS codes for initial physician evaluation (G0245), follow-up physician evaluation (G0246) and routine foot care of a diabetic patient (G0247) are the correct codes to bill for a patient with diabetic neuropathy resulting in a loss of protective sensation. According to the National Correct Coding Initiative (NCCI) PTP edits, CPT® codes for nail debridement (11720 and 11721) bundle in to the HCPCS codes for routine foot care for diabetics (G0245, G0246 and G0247). The modifier indicator on the NCCI PTP edit table is “0.” There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair, and no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider. Only the G codes are payable. To find the reimbursable code of a PTP code pair in the Practitioner PTP edits tables, see the CMS website link at [National Correct Coding Initiative Edits](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

**Q. If providers are from the same practice or share hospital charts, is it necessary for each to document last date treated in every note for nail debridement?**

A. The *Medicare Benefit Policy Manual* (Chapter 15, Section 290) states, “The name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim. In those cases, where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.” Note the requirement is for the claim, not the medical record. This information is available at the link, *Medicare Benefit Policy Manual, Chapter 15 (Section 290)* ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)).

**Q. If a provider’s documentation meets criteria for medical necessity for nail care, does a provider need to use the Q modifiers?**

A. Q modifiers should be appended to claims if the medical necessity is based on a systemic disease. See LCD L33636 from NGS for a description of class findings and modifiers Q7, Q8 and Q9. Select the following link to review this document: [NGS LCD L33636](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33636&ver=30&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=qAAAABAAAAAA%3d%3d&).

**Q. If a patient has both posterior pulses absent, can you use class finding of Q8?**

A. No. Each foot only has one posterior tibial pulse. In order to use the Q8 modifier for class B findings, the patient would need to have two separate class B findings. For details on class findings, see the following WPS web link: [Class Findings Modifier Fact Sheet](http://www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-class-findings.shtml?wb48617274=E903A3E3).
**Q. If a patient exhibits physical exam findings that meet Q8 or Q9 and does not have a systemic condition on the list, can I provide an out-of-pocket nail trimming service with an ABN?**

A. The list in Chapter 15 (Section 290) of the *Medicare Benefit Policy Manual* is not intended as a comprehensive list. If the beneficiary has a metabolic, neurologic, or peripheral vascular disease and physical exam findings, routine foot care may still be justified. If they do not have a systemic disease, then you may have the beneficiary sign an ABN. For more information about the ABN, select the following link: [Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6563.pdf).

**METHODS & RESULTS**

**Q. I was shown to be “Significantly Higher,” yet my actual patient list used for this code is low relative to other practices. I’d like to know more about the use of CPT® code 11721 and understand how statistics for use of that code is determined.**

A. The second analysis, *Percentage of Nail Debridement Services billed as CPT® Code 11721*, compares the proportion of services billed as CPT® code 11721 compared to all nail debridement services (i.e., CPT® codes 11720 and 11721). The overall size of your practice (number of patients) only factors into part of your significance. Significance is based on the proportion of services billed, not the number of patients billed. So it would be possible for your practice to have only a few patients receiving CPT® code 11721, but also be receiving a lot of services proportionally.

**Q. Does the report take into account diagnosis codes (for example: if the practice is almost exclusively diabetic, there will be more CPT® Code 11720 services in comparison to other practices)?**

A. No. **Table 2: Summary of Your Utilization** is intended for information only. The metrics chosen for this CBR compare providers on a per beneficiary/visit basis or on the overall percentage of services billed for these codes. This was done so that high utilization would not be the only factor in determining receipt of a CBR. CBR201608 did not factor diagnosis codes into any analysis. While we understand that patient acuity levels may differ among practices, we encourage providers to perform self-audits to ensure they are within the guidelines provided by their MACs and LCDs. For resources that can help with setting up an audit process, please visit our CBR website page at [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).
Q. Your methods do not consider that some providers are more surgical than others, resulting in more comprehensive examinations with proper documentation nor do they consider that a provider simply elects not to provide foot care services that are deemed elective. How can you purport that your information is accurate when it is based on singular data (which codes I billed) instead of comprehensive data?

A. Due to the vast amount of data available, the CBR team elected to review specific codes for analysis. The purpose of the CBR is to show providers how their billing patterns of specific areas compare to their peers. Of course, there can be legitimate reasons a provider’s billing differs from one’s peers. We encourage providers to perform self-audits to ensure they are within the guidelines provided by their MACs and LCDs. For resources that can help with setting up an audit process, please visit our CBR website page at Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

Q. I do not understand how the results will affect my practice and how I am to both continue to serve the needs of my Medicare patients and still fall within "normal" guidelines?

A. CBRs are for educational and comparison purposes and do not imply wrong-doing. We recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed. CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS’ files, and review Medicare guidelines to ensure compliance. Receiving a report indicating that you are not within the “normal” range of your peers does not necessarily indicate that you need to change your behavior; however, we do recommend that all providers perform self-audits to ensure that they are within the guidelines provided by their MACs and LCDs. For resources that can help with setting up an audit process, visit our CBR website page at Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

Q. Are these reports based on claims sent only to Palmetto or do they also include other MACs?

A. No. These reports are analyses of all Original Fee-for-Service Medicare Part B claims with allowed services for the CPT® codes listed in the report, with dates of service from January 1, 2015 to December 31, 2015. Claims with rendering NPI specialty denoted as podiatry (48) and rendered in the office (11) were included in the analyses. Furthermore, we restricted our analyses to only those providers with allowed nail debridement services. This analysis was based on the latest version of claims available as of April 11, 2016 from the Integrated Data Repository (IDR), which includes claims from all Medicare Administrative Contractors (MACs). Please visit the CMS website at the following link for more information on the IDR: CMS Integrated Data Repository (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/).
Q. The American Podiatric Medical Association (APMA) estimates that there are 15,000 podiatrists. The Department of Labor and Statistics estimates that there are just under 10,000 practicing podiatrists. CBR Letters went out to 8,000 podiatrists that were identified as “outliers,” so the statistics seem to suggest that 53 to 80 percent of podiatrists are “outliers.” How many podiatrists are listed as providers for Medicare?

A. CBRs provide comparative data on how an individual health care provider’s billing and payment patterns compare to his/her peers. The reports are for educational and comparison purposes and do not indicate any wrong-doing. Furthermore, receiving a CBR is not an indication that a provider is an outlier. It is an indication that the provider is different on at least one of the measures covered in the CBR. Because there are multiple measures analyzed, the likelihood of receiving a CBR may be higher than expected. The IDR national Medicare database revealed more than 12,000 podiatrists met the criteria for inclusion in this CBR analysis.

Q. What is the national average for the billing of nail trimming versus nail debridement?

A. This study did not analyze nail trimming data.

Q. What is the significance of Table 6?

A. Recent reviews of E/M services billed with modifier 25 in conjunction with nail debridement services have indicated high claims error rates. In general, E/M services on the same date of service as the minor surgical procedure are included in the payment of the procedures. Only those significant and separately identifiable E/M services unrelated to the decision to perform the minor surgical procedure should be reported with modifier 25. Table 6 provides a comparison of your average minutes of E/M services per visit appended with modifier 25 and without modifier 25. Your averages are compared to that of your state and the nation. To view the average minutes of EM services per visit appended with modifier 25 and without modifier 25 for each state and the nation, please select the following link: Average Minutes of E/M Services per Visit Appended with Modifier 25 and without Modifier 25 (http://www.cbrinfo.net/assets/cbr201608-average-minutes-of-em-services-per-visit-appended-with-modifier-25-and-without-modifier-25.xls).

Q. Regarding the calculations related to average number of minutes for a visit, please explain how 12.03 minutes versus 11.70 minutes was categorized as "Significantly Higher" versus simply "Higher?"

A. A comparison is classified as Significantly Higher if the provider’s value is higher than the comparison data and significance is indicated by the statistical test. In this case, the test is a standard t-test, which takes in to account the amount of data and the variance of the data for each provider. The alpha value for the test is 05.
Q. Should providers strive for “comparative” and/or “does not exceed” on all measures?

A. The CBR is provided as an educational tool giving providers an opportunity to compare themselves to their peers, check their records against data in CMS' files, and review Medicare guidelines to ensure compliance. We recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed for the CBR. We recommend that you conduct a self-audit to determine if process changes are indicated. For resources related to setting up an audit process, please visit our CBR website page at [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).
REFERENCES & RESOURCES

**CBR201608 Webinar Information** ([http://www.cbrinfo.net/cbr201608-webinar.html](http://www.cbrinfo.net/cbr201608-webinar.html))

**Medicare Coverage Database** ([http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAA%3d%3d&=](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAA%3d%3d&=))


**CBR201608 Sample CBR** ([http://www.cbrinfo.net/cbr201608-sample-cbr.html](http://www.cbrinfo.net/cbr201608-sample-cbr.html))


**CBR201608 Statistical Debriefing** ([http://www.cbrinfo.net/cbr201608-statistical-debriefing.html](http://www.cbrinfo.net/cbr201608-statistical-debriefing.html))

**CBR201608 Recommended Links** ([http://www.cbrinfo.net/cbr201608-recommended-links.html](http://www.cbrinfo.net/cbr201608-recommended-links.html))

**Self-Audit Help** ([http://www.cbrinfo.net/self-audit-help.html](http://www.cbrinfo.net/self-audit-help.html))


**Medicare Claims Processing Manual, Chapter 26**

**Prolonged Services (Codes 99354 - 99359)**

**Modifier XS Fact Sheet**
(http://www.wpsmedicare.com/j5macparta/resources/modifiers/modifier-xs.shtml)

**National Correct Coding Initiative Edits**
(https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html)

**NCD 70.2.1**

**Medicare Advance Beneficiary Notices**

**Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)**

**Modifier GA Fact Sheet**
(http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier-ga.shtml)

**CGS Administrators LCD L34246**
(https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34246&ver=5&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11720&bc=gAAAAABAAAAA%3d%3d&)

**FFS ABN**
(https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)

**Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals**

**Novitas LCD L35013**
(https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35013&ver=10&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAAABAAAAA%3d%3d&)

**NGS LCD L33636**
(https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33636&ver=30&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAAABAAAAA%3d%3d&)

**Avoiding Medicare Fraud and abuse: A Roadmap for Physicians**
(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_Fraud_A_Physicians_FactSheet_905645.pdf)

**Billing/Coding Guidelines Article**
(https://downloads.cms.gov/medicare-coverage-
Learn Proper Coding for Modifiers 59 and 25
(http://www.acpinternist.org/archives/2012/07/coding.htm?wb48617274=3E1AFF86)

FCSO LCD L33922 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33922&ver=3&CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=11721&bc=gAAAAABAAAAAA%3d%3d&)

AMA Store (https://commerce.amassn.org/store/catalog/subCategoryDetail.jsp?category_id=cat1150007&navAction=push)

PTP Coding Edits (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)

