

PART B



Foot Care Billing Guide October 2010

NHIC, Corp.

Foot Care Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Foot Care billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-1, Chapter 5, Publication 100-2, Chapter 15, and Publication 100-3, Chapter 1 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.gov/manuals/>

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

Medicare covers only those services and functions that physicians are legally authorized to perform under Federal and State laws, for the state in which they are performed. The performance of services and functions must be consistent with the physician's scope of practice.

Evaluation and Management services billed by providers must be limited to those procedures and determinations which are within their scope of practice. The procedure code billed must be reflective of the actual service performed. A provider may not bill for an evaluation and management service instead of the actual procedure or service that was performed.

By submitting a properly completed CMS-1500 claim form (or electronic equivalent), the provider certifies that the services or items billed were provided and were medically reasonable and necessary for the diagnosis listed.

PROVIDER QUALIFICATIONS

The professional services furnished by providers within the scope of his/her applicable State license (except services which are specifically excluded) are physician's services payable on a reasonable charge basis under Part B. Where permissible by State law, these services include ordering laboratory tests that are reasonably related to the legal scope of practice, that are reasonable and necessary for the diagnosis or treatment of a patient's condition and are not in connection with excluded services, such as treatment of flat foot and routine foot care.

Podiatrist Information

A doctor of podiatric medicine may hold any of the following professional degrees:

Pod. D. or D. P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropodist, Graduate Chiropodist, or in some instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from state to state as to the authorized scope of podiatric practice.

For purposes of the Medicare program, a doctor of podiatric medicine is considered a physician for any of the following purposes:

- Making the required physician certification and recertification of the medical necessity for services;
- Having a patient in a home health agency under his/her care, and establishing and periodically reviewing a home health plan of treatment; or
- Serving as a member of a Utilization Review (UR) committee, but only if at least two of the physicians on the UR committee are doctors of medicine or osteopathy. The performance of these functions must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

MEDICAL NECESSITY

In order to be covered under Medicare, a service shall be reasonable and necessary. Medicare considers a service to be reasonable and necessary when the service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
 - Furnished in a setting appropriate to the patient's medical needs and condition;
 - Ordered and furnished by qualified personnel;
 - One that meets, but does not exceed, the patient's medical need; and
 - At least as beneficial as an existing and available medically appropriate alternative.

NURSING FACILITY ASSESSMENTS

Nursing Facility Assessment services describe evaluation and management services of a new or established patient involving an annual nursing facility assessment (99304), or initiation of a new medical plan of care (99305) or an admission/readmission with development of a new medical plan of care (99306). These procedures require development of a comprehensive medical plan of care, assessment of the entire physical, mental and psychosocial well being of the beneficiary.

The podiatry scope of practice does not include the total management of a patient's condition, nor does it include creation or review of a total care plan of a nursing home patient. Medicare payment cannot be issued for services rendered outside the scope of a provider's practice. Providers, therefore, may not report codes, CPT 99304, CPT 99305, or CPT 99306. Providers should instead report the appropriate foot care service code or, when indicated, evaluation and management service codes 99307-99310, or inpatient consultation evaluation and management service codes, 99251-99255, as appropriate to report medical evaluation and management of the foot or ankle rendered to nursing facility patients.

MEDICAL RECORDS

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
 - Reason for encounter and relevant history;
 - Physical examination findings and prior diagnostic test results;
 - Assessment, clinical impression, and diagnosis;
 - Plan for care; and
 - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported should be supported by documentation in the medical record.

NEW PATIENT VISITS

A physician may bill a **new patient visit** if the patient has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.

CONSULTATIONS

Effective prior to January 1, 2010, for Medicare payment to be made for a consultation, all criteria for the use of a consultation code must be met:

- Specifically, a consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).
- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

ROUTINE FOOT CARE

Except as provided in the "Exceptions to Routine Foot Care Exclusion" below, routine foot care is statutorily excluded from coverage under Medicare. For Medicare Part B purposes, routine foot care services include:

- Cutting or removal of corns and calluses;
- Trimming, cutting, clipping, or debriding of nails;
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and
- Any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

These services are usually provided by the beneficiary themselves, a family member, friend, or caregiver.

The exclusion of foot care is determined by the nature of the service. Thus, payment for an excluded service should be denied whether performed by a podiatrist, osteopath, or a doctor of medicine, or qualified Non Physician Practitioners and without regard to the difficulty or complexity of the procedure.

Exceptions to Routine Foot Care Exclusion

- Services performed as a necessary and integral part of otherwise covered services such as diagnosis and treatment of ulcers, wounds, infections, and fractures.
- The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease that may require scrupulous foot care by a professional. Certain procedures that are otherwise considered routine may be covered when systemic condition(s), demonstrated through physical and/or clinical findings, result in severe circulatory embarrassment or areas of diminished sensation in the legs or feet and may pose a hazard if performed by a nonprofessional person on patients with such systemic conditions.

In the case of patients with systemic conditions such as diabetes mellitus, chronic thrombophlebitis, and peripheral neuropathies involving the feet associated with malnutrition and vitamin deficiency, pernicious anemia associated with carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis and uremia, must also be under the **active care** of a doctor of medicine or doctor of osteopathy who documents the condition in the patient's medical record.

NOTE: Active care is defined as treatment and/or evaluation of the complicating disease process during the six-month period prior to rendition of the routine care. When billing for services related to asterisked conditions, indicate date last seen and NPI or for services on or when it is required, the NPI of attending physician in item 19 of the CMS-1500 claim form, or its electronic equivalent.

Please refer to the routine foot care Local Coverage Determination for your region to determine if your diagnosis code requires active care of a physician. The LCDs can be found by visiting www.medicarenhic.com, and then clicking on LCDs. The list of LCDs and procedure codes are on the website for your convenience, and are listed in alphabetical order.

- Patients with a documented diagnosis of peripheral neuropathy and loss of protective sensation (LOPS) and no other physical and/or clinical findings can receive an evaluation and treatment of the feet no more often than every six months as long as they have not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) guidelines. Five sites should be tested on the plantar surface of each foot, according to NIDDK guidelines.
- Treatment of warts, including plantar warts, may be covered. Coverage is to the same extent as services provided for in treatment of warts located elsewhere on the body.
- 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 (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.

Treatment of mycotic nails for a **no ambulatory** patient is covered only when the physician attending a patient's mycotic condition documents in the medical record that (1) there is clinical evidence of mycosis of the toenail and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Class Findings

A presumption of coverage may be made where the claim or other evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, the following findings are pertinent:

Class A Findings

- Nontraumatic amputation of foot or integral skeleton portion thereof

Class B Findings

- Absent posterior tibial pulse
- Advanced trophic changes; three of the following are required: hair growth (decrease or absence), nail changes (thickening), pigmentary changes (discoloration), skin texture (thin, shiny), skin color (rubor or redness)
- Absent dorsalis pedis pulse

Class C Findings

- Claudication
- Temperature changes
- Edema
- Paresthesia
- Burning

The following modifiers are associated with class findings:

- Q7 One class A finding;
- Q8 Two class B findings; or
- Q9 One class B finding and 2 class C findings.

Qualified Routine Foot Care Billing

Routine foot care is identified using the following codes:

11055 – trim skin lesion
11056 – trim skin lesions, 2 to 4
11057 – trim skin lesions, over 4
11719 – trim nail(s)
11720 – debride nail, 1-5
11721 – debride nail 6 or more
G0127 – trim nail(s)

If qualifications for coverage are met, these services are typically covered once every 60 calendar days.

More frequent treatment requires supporting documentation indicating the medical necessity of the increased frequency. If the supporting documentation is not submitted, these services will be denied. The denial would then need to be appealed, with the supporting documentation attached to the appeal request.

The systemic condition must be listed in item 21 and referenced in 24E on the CMS 1500 claim or electronic equivalent.

For conditions requiring class findings, the appropriate modifier must be submitted on the claim in item 24D.

FOOT CARE RELATED SERVICES

Diabetic Sensory Neuropathy with Loss of Protective Sensation (Diabetic Peripheral Neuropathy)

Presently, peripheral neuropathy, or diabetic sensory neuropathy, is the most common factor leading to amputation in people with diabetes. In diabetes, sensory neuropathy is an anatomically diffuse process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Diabetic sensory neuropathy with LOPS is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule. Foot exams for people with diabetic sensory neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Medicare covers, as a physician service, an evaluation (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. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of 5 tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and

investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

The physician's evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) includes:

- A patient history, and
- A physical examination that consists of at least the following elements:
 - Visual inspection of the forefoot, hindfoot, and toe web spaces,
 - Evaluation of a protective sensation,
 - Evaluation of foot structure and biomechanics,
 - Evaluation of vascular status and skin integrity, and
 - Evaluation and recommendation of footwear; and
- Patient education

The treatment includes, but is not limited to:

- Local care of superficial wounds,
- Debridement of corns and calluses, and
- Trimming and debridement of nails.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

G0245 – Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS).

G0246 – Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS.

G0247 – Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS).

Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

Skin Debridement (11040-11044)

Debridement of the skin is the removal of tissue by cutting with a surgical instrument. The medical record should indicate the size, depth (or grade) and appearance of the ulcer or wound, as well as the type of or depth of tissue or material removed.

Avulsion or Excision of Toenail Plate (11730, 11732, 11750)

An ingrown nail is a condition which results in the growth of the nail edge into the surrounding soft tissue, resulting in acute inflammation and/or pain, and/or ischemic soft tissue changes. An infection may or may not be present.

- Avulsion of toenail plate, CPT codes 11730, 11732, is defined as removing part or all of the toenail through at least half the length of the nail
- Excision of nail and nail matrix, CPT code 11750, requires removal of part or all of the nail along its length, with destruction or permanent removal of the matrix by any means.

Incision and Drainage of Abscess (10060, 10061, 10160)

Incision and drainage is the cutting of a wound to allow for the flow or withdrawal of fluids. When a patient requires these procedures to be recurrently performed, the medical record must reflect the reason for persistent or recurrent infections and a plan of future preventative measures being taken.

Debridement of the Toenails (11720-11721) LCD (L3176)

Nail debridement involves reduction of nail bulk and girth to the level of expected reasonably normal nail thickness. Trimming of nails involves reduction in nail length. Trimming the ends of the toenails is not considered debridement. One of the following PRIMARY diagnosis codes (group 1) must be present on the claim:

110.1	Mycotic Toenails: Fungal infection of the toenails
703.0	Other Specified Diseases of Nail
703.8	Onychogryposis: Enlargement with increased thickening and curvature of the toenails, or marked overgrowth of the toenails;
757.5	Specified Congenital Anomalies of nails

A SECONDARY diagnosis code in group 2 below describing the **systemic** condition must be present on the claim IN ADDITION to one of the primary diagnosis codes above.

030.0-030.9 Lepromatous Leprosy (Type L) – Leprosy Unspecified

094.0-094.9 Tabes Dorsalis – Neurosyphilis Unspecified

249.00-250.93* Secondary diabetes Mellitus without mention of complication, not stated as uncontrolled, or unspecified – Diabetes with unspecified complication, type 1

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	(juvenile type), uncontrolled.
265.2*	Pellagra
272.7	Lipidoses
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean Fever
277.39	Other amyloidosis
281.0*	Pernicious Anemia
286.9	Other and unspecified coagulation defects
340*	Multiple Sclerosis
356.0-357.9*	Hereditary peripheral neuropathy – unspecified inflammatory and toxic neuropathies
440.20-440.29	Atherosclerosis of native arteries of the extremities unspecified – other atherosclerosis of native arteries of the extremities
443.1	Thromboangiitis obliterans (Buerger's disease)
443.9	Peripheral vascular disease unspecified
451.11-451.19*	Phlebitis and thrombophlebitis of femoral vein (deep) (superficial) – phlebitis and thrombophlebitis of other
579.0*	Celiac disease
579.1	Tropical Sprue
585.1*	Chronic kidney disease, stage I
585.2*	Chronic kidney disease, stage II (mild)
585.3*	Chronic kidney disease, stage III (moderate)
585.4*	Chronic kidney disease, stage IV (severe)
585.5*	Chronic kidney disease, stage V
585.6	End Stage Renal disease
585.9*	Chronic kidney disease, unspecified
956.0-956.9	Injury to sciatic nerve – injury to unspecified nerve of pelvic girdle and lower limb

NOTE: When the patient's condition is one of those designated by an asterick(*) above, routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the conditions.

A SECONDARY diagnosis code in group 3 below describing the diagnosis for debridement of mycotic nails in the **absence of a systemic condition** must be present on the claims in ADDITION to one of the PRIMARY diagnosis codes in group 1 in order to be covered.

110.4 Dermatophytosis of foot

681.10-681.11 Unspecified cellulitis and abscess of toe – onychia and paronychia of toe

719.7 Difficulty in walking

729.5 Pain in limb

The patient's ambulatory or non-ambulatory status and the medical necessity and frequency of treatment must be documented in the medical record and available upon the request of NHIC, Corp. It is not medically necessary to render the service less than 60 days apart. More frequent treatment requires supporting documentation indicating the medical necessity of the increased frequency.

The primary diagnosis must be submitted in item 21 and on the detail line (item 24E) and the secondary diagnosis must be submitted in item 21 only.

Foot and Ankle Strapping (29540, 29550)

Adhesive application for the purpose of immobilization is covered. The medical record should support the medical necessity and frequency of this treatment.

Unna Boot (29580)

An Unna Boot is considered to be a compression dressing, not a cast. Therefore, the supply for Unna boots is included in the payment of the procedure and not paid separately.

EXCLUSIONS

There are some conditions that are specifically excluded from coverage according to the CMS Internet Online Manual (IOM) System. These conditions are identified below.

Treatment of Flat Foot

Flat Foot is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are **not covered**.

Treatment of Subluxation of the Foot

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or non surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are **not covered**.

However, medical or surgical treatment of subluxation of the ankle joint (talo-crural joint) is covered. In addition, reasonable and necessary diagnosis, and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion) and tendonitis that have resulted from or are associated with partial displacement of structures is covered. For example, if a patient has osteoarthritis that has resulted in a partial displacement of joints in the foot, and the primary treatment is for the osteoarthritis, coverage is provided.

Supportive Devices for the Feet

Orthopedic shoes and other supportive devices for the feet are **not covered**. However, this exclusion does not apply to a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics. Claims for these items must be submitted to the Durable Medical Equipment Regional Carrier (DMERC).

MEDICAL CARE SAME DAY AS MINOR SURGICAL PROCEDURE

The Centers for Medicare & Medicaid Services (CMS) has classified a number of foot procedures as minor surgeries. Visits performed on the same day as a minor surgical procedure by the same physician/group are not reimbursable unless the visit is for a significant, separately identifiable E&M service. Modifier **25** can be used to indicate that the patient's condition warranted a separate E&M service above and beyond the care normally associated with the minor surgical procedure. Modifier **25** is only to be used for an eligible visit which was performed on the same day (by the same physician) as minor surgery. Medical records should clearly document the need for the separate E&M service and modifier **25** should be appended to the appropriate E&M code.

GLOBAL SURGERY

The "global surgical fee" includes all usual and customary services performed by the physician the day before (for major surgeries) the day of (for major or minor surgeries), during and after a surgical procedure. Medicare payment for a given surgical procedure includes applicable preoperative care, intraoperative care, complications, and postoperative care. Services included in a global surgery package may be rendered in any setting, such as hospitals, ambulatory surgical centers, and physicians' offices. The decision for surgery whether minor or major determined within 24 hours of performance of the surgery may define a significant separately identifiable evaluation and management service. As such, the E&M service associated with a decision for surgery of a minor procedure would be appended with a "25" modifier; the E&M service associated with a decision for surgery of a major procedure would be appended with a "57" modifier."

MODIFIERS

Modifiers for Class Findings

Q7	One class A finding
Q8	Two class B findings
Q9	One class B and two class C findings

Digit Modifiers

With some procedure codes, it is appropriate to report a digit modifier indicating the toe upon which the procedure was performed. A toe is defined as that appendage structure distal to the mid-metatarsal-phalangeal joint. Digital modifiers are:

TA	Left foot, great toe	T5	Right foot, great toe
T1	Left foot, second digit	T6	Right foot, second digit
T2	Left foot, third digit	T7	Right foot, third digit
T3	Left foot, fourth digit	T8	Right foot, fourth digit
T4	Left foot, fifth digit	T9	Right foot, fifth digit

SURGICAL CASTING

The allowance for reduction of a fracture includes an allowance for the application of the first cast or traction device. Therefore, castings put on at the time of surgery are included in the surgical procedure's fee schedule allowance, and includes cast removal. Subsequent castings may be allowed separately. A casting is considered "subsequent" any time after the date of the surgery.

BILLING REQUIREMENTS

The following information is frequently used when submitting foot care claims. The new version of the form CMS-1500 (08/05) provides specific fields for NPI numbers, and is the form all paper claim submitters should be using.

- Item 17. Enter the name of the **referring** or **ordering** physician if the service or item was ordered or referred by a physician. A referring physician is a physician who requests an item or service for the patient for which payment may be made.
Item 17b– Enter the NPI number of the referring or ordering physician.

- Item 19. Enter the 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date patient was last seen and the NPI of his/her **attending** physician when a physician providing routine foot care submits claims.
- Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity.
- Item 24D. Enter the procedures, services, or supplies using the HCPCS/CPT code. When applicable, show the appropriate modifiers.
- Item 24E. Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service; enter either a 1, or 2, or a 3, or 4.

If a situation arises where two or more diagnoses are required for a procedure code, you must reference only one of the diagnoses listed in item 21 in item 24E.

NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address: <http://www.cms.gov/BNI/>

ABN Modifiers

- GA Waiver of liability statement issued, as required by payer policy
- GX Notice of liability issued, voluntary under payer policy
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- GZ Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml

NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.gov/mcd/search.asp>

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

RECOVERY AUDIT CONTRACTOR

The Centers for Medicare & Medicaid Services (CMS) has retained Diversified Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on <http://www.dcsrac.com/>

COMPREHENSIVE ERROR RATE TESTING

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

CERT DOCUMENTATION CONTRACTOR (CDC) - The CDC requests and receives medical records from providers.

CERT REVIEW CONTRACTOR (CRC)-The CRC's medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on <http://www.cms.gov/CERT/>

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or SSN of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 4:00 p.m. - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Thursday

10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 809150 Chicago, IL 60680-9150
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

C2C Solutions, Inc.

QIC Part B North Reconsiderations

P.O. Box 45208

Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.gov/center/coverage.asp>

<http://www.cms.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

<http://www.cms.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

<http://www.cms.gov/CMSForms/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.gov>
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.gov/NationalCorrectCodInitEd/>

CMS Physician's Information
Resource for Medicare

<http://www.cms.gov/center/physician.asp?>

Electronic Prescribing

<http://www.cms.gov/erxincentive/>

Foot Care Billing Guide

Evaluation and Management Documentation Guidelines

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

<http://www.cms.gov/HIPAAGenInfo/>

National Provider Identifier (NPI)

<http://www.cms.gov/NationalProvIdentStand/>

NPI Registry

<https://nppes.cms.gov/NPPES/NPIRegistryHome.do>

Physicians Quality Reporting

<http://www.cms.gov/pqri/>

Provider Enrollment, Chain, and Ownership System (PECOS)

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment

<http://www.cms.gov/MedicareProviderSupEnroll/>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	7/06/2010	Susan Kimball	Ayanna YanceyCato	Release of document on the new NHIC Quality Portal
2.0	08/25/2010	M. Franco	Ayanna YanceyCato	Updated CMS links and Refunds bank info
3.0	10/19/10	Susan Kimball	Ayanna Yancey Cato	Updated QIC name

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

<http://www.cms.gov>

<http://www.medicare.gov>