# INSURANCE REPORT
## FPMA Board Meeting
### March 26, 2022

**Insurance Committee:** Dr. Mark S. Block

I have received and continue to evaluate, organize, and act on a large volume of communications received since my last published insurance report. I have attempted to prioritize insurance issues that could potentially impact our profession and health care. As always, I review and make every effort to provide an accurate representation of the more significant items/issues. To fulfill this goal, I have included communications, background information, and citations.

As noted in previous updates to the membership, this report is quite lengthy. As in the past, numerous pages of summation and communications were reviewed and analyzed. To provide a meaningful submission of material and information, I took the liberty of not including less significant items or communications that would appear redundant. (This report would have been substantially longer had all communications and information been included.)

Numerous hours went into this report to provide membership with significant and relevant information. As I previously stated, it is my opinion that an understanding of this material will assist, not only in the care of our patients, but also in facilitating decisions and ultimately decreasing the burden of managing our practices.

To further assist the membership and provide clarification on certain topics, I have provided synopsis/background information. I have also included significant emails. I believe providing this information affords a better understanding of those respective topics and issues. Some of the email threads were also provided to explain the topic and magnitude of challenging issues. (Note the dates on email threads to appreciate a better understanding of the sequence.) In some cases, I intentionally duplicated communications/information to facilitate an appreciation of the specific topics and issues.

I remain available to answer any additional questions and provide guidance, if applicable or needed. In addition, I included pertinent publications and articles written by others to provide helpful information and background material. These are communications that contain relevant issues, opinions, and information for guidance purposes.

I have provided summaries of the issues presented in this report at the FPMA Board meeting and will present them at future relevant venues.

Please Note:

- In this report, I have provided a series of communications received since the publication of my last report. When reading the report, one may notice that some of these issues have, to date, been resolved. However, I am submitting them here to inform the reader of the chain of events.

- I receive numerous inquiries, mostly via email. In the past, I have published these communications. Moving forward, I have archived them for present and future reference and will incorporate select ones into my report as deemed helpful.

- Every effort was made to redact names, addresses, emails, etc. where appropriate. In the event any of this information was inadvertently included, I respectfully request that this information be redacted from any of the reader's communications to protect the entities/information provided.

- Most of the emails/communications are listed in reverse order. These are in the format of an email thread, with the most recent communications listed first.

As noted, an effort was made to provide comprehensive and relevant information. Some topics may have little or no significance for some providers. To assist in reviewing this material, I categorized the report topics (i.e., I, II, III, IV, etc.) to allow readers to bypass those areas they may find not significant or relevant to their practice.

**The following index is a generalized breakdown of items in this Insurance Report.**

**INDEX:**

# I

# MEDICARE

**1)**

**a)**

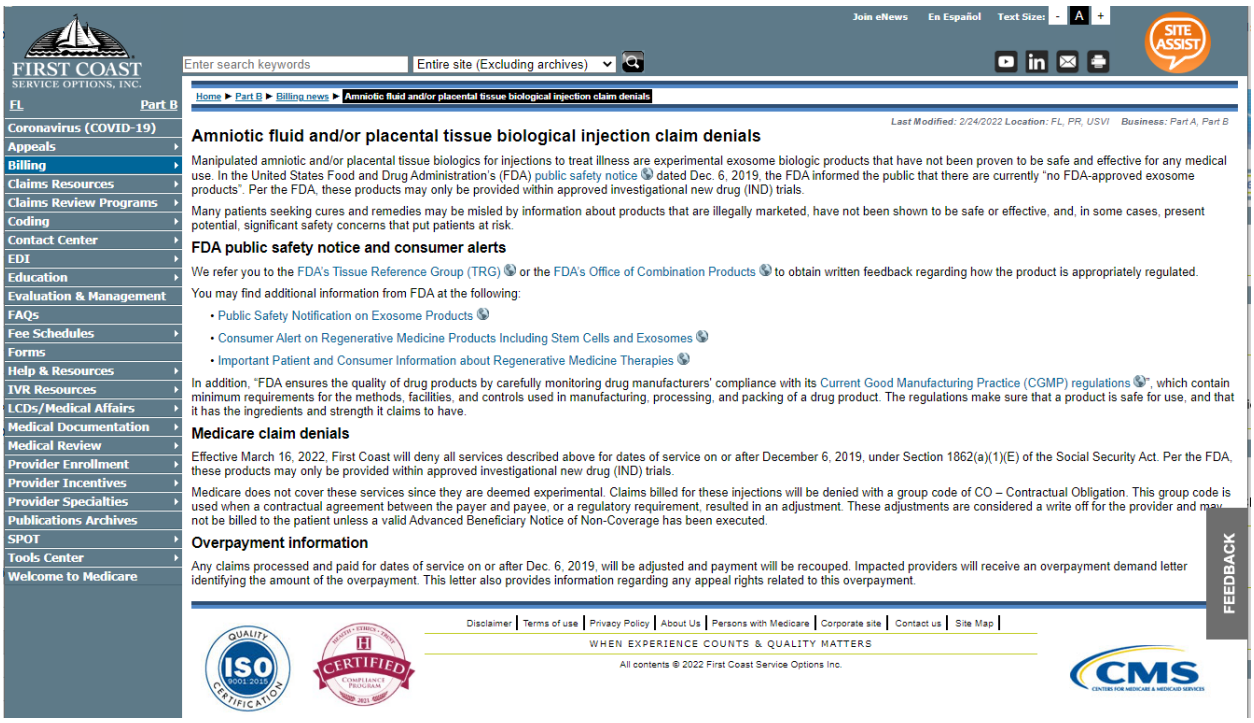
**Amniotic fluid and/or placental tissue biological injection claim denials.**

**The following FCSO communication was published in February. It states that all claims on or after December 6, 2019 will be denied. I have heard from a few members who received letters from the carrier regarding denials (see copy below).**

**The following link will take you to the page below:**
**https://medicare.fcso.com/Billing_news/0493589.asp**

**Links providing additional information will be available if further clarification is desired.**

**There has been some confusion that this includes wound care utilization of these products. Be advised that this directive does not. When utilizing for wounds, providers should refer to the requisite LCD and Article, which has not changed.**



FIRST COAST SERVICE OPTIONS, INC.

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Enter search keywords | Entire site (Excluding archives)

FL | Part B

- Coronavirus (COVID-19)
- Appeals
- Billing
- Claims Resources
- Claims Review Programs
- Coding
- Contact Center
- EDI
- Education
- Evaluation & Management
- FAQs
- Fee Schedules
- Forms
- Help & Resources
- IVR Resources
- LCDs/Medical Affairs
- Medical Documentation
- Medical Review
- Provider Enrollment
- Provider Incentives
- Provider Specialties
- Publications Archives
- SPOT
- Tools Center
- Welcome to Medicare

Home ▶ Part B ▶ Billing news ▶ Amniotic fluid and/or placental tissue biological injection claim denials

*Last Modified: 2/24/2022 Location: FL, PR, USVI Business: Part A, Part B*

## Amniotic fluid and/or placental tissue biological injection claim denials

Manipulated amniotic and/or placental tissue biologics for injections to treat illness are experimental exosome biologic products that have not been proven to be safe and effective for any medical use. In the United States Food and Drug Administration's (FDA) public safety notice dated Dec. 6, 2019, the FDA informed the public that there are currently "no FDA-approved exosome products". Per the FDA, these products may only be provided within approved investigational new drug (IND) trials.

Many patients seeking cures and remedies may be misled by information about products that are illegally marketed, have not been shown to be safe or effective, and, in some cases, present potential, significant safety concerns that put patients at risk.

### FDA public safety notice and consumer alerts

We refer you to the FDA's Tissue Reference Group (TRG) or the FDA's Office of Combination Products to obtain written feedback regarding how the product is appropriately regulated.

You may find additional information from FDA at the following:

- Public Safety Notification on Exosome Products
- Consumer Alert on Regenerative Medicine Products Including Stem Cells and Exosomes
- Important Patient and Consumer Information about Regenerative Medicine Therapies

In addition, "FDA ensures the quality of drug products by carefully monitoring drug manufacturers' compliance with its Current Good Manufacturing Practice (CGMP) regulations", which contain minimum requirements for the methods, facilities, and controls used in manufacturing, processing, and packing of a drug product. The regulations make sure that a product is safe for use, and that it has the ingredients and strength it claims to have.

### Medicare claim denials

Effective March 16, 2022, First Coast will deny all services described above for dates of service on or after December 6, 2019, under Section 1862(a)(1)(E) of the Social Security Act. Per the FDA, these products may only be provided within approved investigational new drug (IND) trials.

Medicare does not cover these services since they are deemed experimental. Claims billed for these injections will be denied with a group code of CO – Contractual Obligation. This group code is used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. These adjustments are considered a write off for the provider and may not be billed to the patient unless a valid Advanced Beneficiary Notice of Non-Coverage has been executed.

### Overpayment information

Any claims processed and paid for dates of service on or after Dec. 6, 2019, will be adjusted and payment will be recouped. Impacted providers will receive an overpayment demand letter identifying the amount of the overpayment. This letter also provides information regarding any appeal rights related to this overpayment.

FEEDBACK

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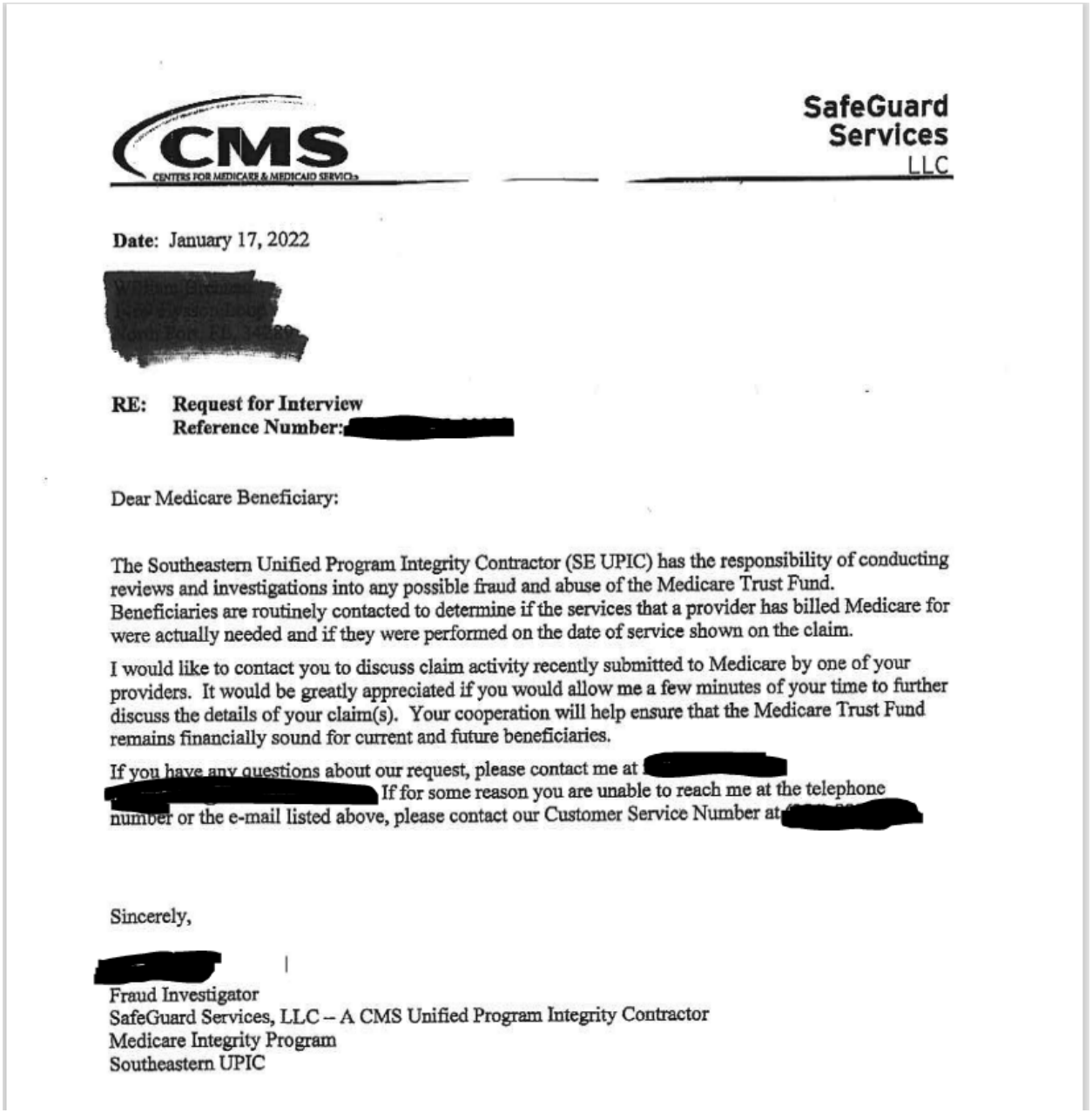
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

**b)**

**Copy of sample letter.**



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

SafeGuard Services LLC

**Date:** January 17, 2022

[redacted]

**RE: Request for Interview**
**Reference Number:** [redacted]

Dear Medicare Beneficiary:

The Southeastern Unified Program Integrity Contractor (SE UPIC) has the responsibility of conducting reviews and investigations into any possible fraud and abuse of the Medicare Trust Fund. Beneficiaries are routinely contacted to determine if the services that a provider has billed Medicare for were actually needed and if they were performed on the date of service shown on the claim.

I would like to contact you to discuss claim activity recently submitted to Medicare by one of your providers. It would be greatly appreciated if you would allow me a few minutes of your time to further discuss the details of your claim(s). Your cooperation will help ensure that the Medicare Trust Fund remains financially sound for current and future beneficiaries.

If you have any questions about our request, please contact me at [redacted] If for some reason you are unable to reach me at the telephone number or the e-mail listed above, please contact our Customer Service Number at [redacted]

Sincerely,

[redacted]
Fraud Investigator
SafeGuard Services, LLC – A CMS Unified Program Integrity Contractor
Medicare Integrity Program
Southeastern UPIC

## c)

## Below is a recent alert I submitted for FPMA publication to the membership dated 3/4/2022.

The Block Report

# The Block Report

**Amniotic Fluid and/or Placental Tissue Biological Injection Claim Denials**

I trust most, if not all, are aware of potential problematic amniotic/placental injection billing issues. The following link should provide background information and guidance: **https://medicare.fcso.com/Billing_news/0493589.asp**

**Important Patient and Consumer Information About Regenerative Medicine Therapies**

To assist, I have provided what I feel is a summary of the issues relevant to our specialty:

Regenerative medicine therapies have not been approved for the treatment of any orthopedic condition, such as osteoarthritis, tendonitis, disc disease, tennis elbow, back pain, hip pain, knee pain, neck pain, or shoulder pain.

The FDA has repeatedly notified manufacturers, clinics, and health care practitioners of the need for Investigational New Drug applications (INDs) to legally administer these products and to ensure safety measures are in place prior to administration.

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair, FPMA Insurance Committee

## d)

## Medicare's message can be summarized as noted below:

*Medicare does not cover manipulated amniotic and/or placental tissue biologics for injections to treat illness since they are deemed experimental. Claims billed for these injections will be denied.*

*These adjustments are considered a write off for the provider and may not be billed to the patient unless a valid Advanced Beneficiary Notice of Non-Coverage has been executed.*

## 2)

## CBR Report

## "Podiatry Nail Debridement & Evaluation and Management Services: Comparative Billing Report"

## The email below includes a communication I had sent to membership regarding this initiative. There are links included that provide guidance and background

**information relating to this initiative. If you were unable to attend the live webinar, there is a link to a prerecorded PowerPoint presentation.**

# FPMA Insurance Alert

March 3, 2022

To FPMA Membership:

CMS recently published the **"Podiatry Nail Debridement & Evaluation and Management Services: Comparative Billing Report"**.

In the past, I have provided presentations and articles on the CBR process. This latest initiative appears to address E&M encounters when billed with nail debridement and other associated issues.

These reports are intended to be educational and informative. They are not intended to imply provider overutilization or inappropriate billing. However, if a provider receives a CBR report, I recommend they evaluate their utilization patterns vs. peers. If necessary, corrective action may be indicated to adjust patterns of utilization and billing.

Some providers' practices may justify their outlier status. However, in other cases, this tool can be useful for self-assessment and the need to adjust billing patterns. There is always the potential of an audit and associated

adjustments/penalties if perceived outlier patterns persist and cannot be reasonably justified.

A more detailed explanation of this process and specific initiative can be obtained via the links below. As always, I will continue to monitor this issue and report and provide guidance if and as needed.

CMS will issue a comparative billing report (CBR) on Medicare Part B claims for podiatry nail debridement and evaluation and management services soon. Use the data-driven report to compare your billing practices with those of your peers in your state and across the nation.

CBRs aren't publicly available. Look for an email from cbrpepper.noreply@religroupinc.com to access your report. Update your email address in the Provider Enrollment, Chain, and Ownership System to ensure delivery.

More Information:

- View a webinar recording
- Visit the CBR website
- Register for a live webinar on March 9 from 3-4 pm ET

**Please Note:**

1. At the time of writing this news item, the CBR reports have not been sent.
2. Not every provider will be sent the reports (as indicated in the information provided via the above links).

Hopefully this information is of assistance.

Fraternally,

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair, FPMA Insurance Committee
FPMA Medicare CAC/PIAC Representative

**3)**

**In August 2021, FCSO requested that I make myself available for a webinar/conference call. The agenda consisted of providing and discussing recommended changes to a draft policy "Surgical Treatment of Nails".**

**In preparation for this call, I researched and provided approximately 20 comments in writing and verbally to substantiate changes that I had requested. In addition, I researched and reached out to APMA as well as other sources that I felt would be of assistance.**

**Apparently, most of the arguments I presented were well received. The end result was a substantially favorable LCD and article that is contained in the finalized LCD/Article.**

**Proposed Local Coverage Determination (LCD):**
**Surgical Treatment of Nails (DL33833)**

**NOTE: I am also providing a companion article under "b)" that directly follows the LCD below.**

**a) The finalized version of the LCD is below.**

**Local Coverage Determination (LCD)**

# Surgical Treatment of Nails

**L33833**

Expand All | Collapse All

## Contractor Information
## LCD Information

Document Information
**LCD ID**
L33833
**LCD Title**
Surgical Treatment of Nails
**Proposed LCD in Comment Period**
N/A
**Source Proposed LCD**
DL33833

**Original Effective Date**
For services performed on or after 10/01/2015
**Revision Effective Date**
For services performed on or after 01/30/2022
**Revision Ending Date**
N/A
**Retirement Date**
N/A
**Notice Period Start Date**
12/16/2021
**Notice Period End Date**
01/29/2022
**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**



## CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for surgical treatment of nails. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing

laws, regulations and rules for Medicare payment for surgical treatment of nails and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

**IOM Citations:**

- CMS IOM 100-08, *Medicare Program Integrity Manual*,
    - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

**Social Security Act (Title XVIII) Standard References:**

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment may be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this LCD may be monitored and addressed through post payment data analysis and subsequent medical review audits.

**History/Background and/or General Information**

There are a number of indications for surgical exploration of the nail unit of the fingers and toes. Surgical nail avulsion may be performed to aid in diagnosis by allowing for the full examination and exploration of the nail bed, the nail matrix, the proximal nail fold (the soft tissue that protects the emerging nail plate), the lateral nail fold (LNF) (extension of the proximal nail fold that protects each side of the nail plate), and the nail grooves for the presence of pathology or as a preliminary step before performing a biopsy on the nail bed and the nail matrix. Indications such as subungual hematomas and tumors, benign or malignant neoplasms and trauma may require access and visualization of the nail bed. Surgical nail avulsion may also be performed for therapeutic management of disease processes, to relieve pain or to correct or prevent anatomical deformities of the nail. Symptomatic disease processes affecting the nail complex that may be managed with surgical intervention include infections, inflammation, onychomycosis (i.e., fungal infection), onychocryptosis (i.e., ingrown nails), onychogryphosis (i.e., hornlike hypertrophy of the nail plate), and onychauxis (i.e., thickened nails), as well as psoriasis, lichen planus, congenital nail dystrophies,[1] and tumors.[2]

Nail treatment and surgical options must be individualized based on the nail condition and careful consideration should be taken when selecting patients for surgical nail procedures. Factors to consider when determining appropriate treatment include the extent of disease, type of organism, and medical comorbidities.[1] Patients with factors that predispose them to infection include but are not limited to those with uncontrolled diabetes mellitus, prior infection with methicillin-resistant Staphylococcus aureus, and immunosuppression.

Medical conditions that impede blood flow or depress immunity may increase the risk of fungal nail infection. Diabetes and circulatory disorders may impair blood flow to the nail beds, increasing the chance of fungal infection. Prevalence in the general population ranges from 2.5% - 5% and is more common in diabetics (13% - 32%). Diabetics, and others suffering from impaired arterial circulation and decreased sensation, may present with more severe cases (i.e., secondary infection, gangrene).[3,4,5]

Ingrown toenails account for approximately 20% of foot problems presented in the primary care setting.[6] An ingrown nail is a condition which results in the growth of the nail edge into the surrounding soft tissue that may result in pain, inflammation, or infection. This condition, although not very often, may involve the fingernails, and is noted in the literature to commonly occur in the great toes.[1,6] No consensus has been reached for the best treatment approach, but ingrown nails may be treated non-surgically or surgically. Non-surgical treatments are typically used for mild to moderate ingrown nails, whereas surgical treatments are typically used in moderate and severe cases.[1,3,6]

Blood underneath a fingernail or toenail or a subungual hematoma, generates pressure between the nail bed and the nail plate where the blood collects and may cause pain. Treatment of a subungual hematoma depends on the type of injury and patient comorbidities or risk factors for complications. A small not too painful hematoma is incorporated into the nail and progressively migrates outward to the free edge of the nail plate as the nail grows out.

In traumatic nail injuries, surgical nail avulsion may be used to evaluate the stability of the nail bed or to release a subungual hematoma after a failed puncture aspiration. Injury of a fingernail may be treated with avulsion with surgical repair of the nail bed.[1,10] For toenail avulsions, a nonadherent, highly absorbent dressing is ideal.[10] A reattachment of the avulsed fingernail or a fingernail substitute, intended to protect the nail bed during the healing process, will adhere to the nail bed within 1 to 3 months and will be pushed off by the new nail, and as noted in this situation, will reach complete growth in 4 to 6 months.[8]

The thickening of the nail plate may be a symptom of nail fungus, psoriasis or other conditions. This thickening (Onychauxis) may force the nail plate to separate from the nail bed (Onycholysis). This condition may last for several months because the finger or toenail will not reattach to its nail bed. Non-surgical treatment consists of clipping off the affected separated portion at the distal end of the of the nail plate and treating the underlying cause. In the case of moderate or severe symptomatic dystrophic nail plate, a surgical intervention may be required.[1,3,6]

A partial or complete avulsion of a nail plate is generally performed under local anesthesia. This surgical procedure involves the separation and a partial removal of a border of the nail plate or removal of the entire nail plate from the nail bed to the eponychium; the surgical removal of the body of the nail plate from its primary attachments, the nail bed ventrally and the proximal nail fold dorsally.

Excision of nail plate and nail matrix is performed under local anesthesia and requires removal of the full length or the entire nail plate, with destruction or permanent removal of the matrix (matrixectomy). Matrixectomy can be performed surgically, chemically, electrosurgically, or with radiofrequency ablation. All are effective options when treating ingrown toenails.[6] Partial matrixectomies may be performed in the management of persistent onycholysis and onychocryptosis. When performed without matrixectomy, in most cases, the nail will regrow from the area under the cuticle (the matrix). A fingernail takes about 4 to 6 months to grow back. A toenail takes about 8 to 12 months to grow back.[7,8]

Wedge excision of skin of the nail fold is designed to relieve pressure on the nail/soft tissue and is an excision of the skin from the involved, medial and/or lateral, side of the toe or finger. The technique of wedge excision often fails to remove the nail spicule. Nail removal without destroying the matrix of the nail that produces nail growth can permit the nail to regrow beneath the nail fold, producing another ingrown nail. The purpose of partial or complete removal of a nail is to decrease the width of the nail plate at the offending border to relieve pain and pressure. This procedure could include removal/destruction of the nail matrix, either surgically or chemically, to cause long-term narrowing of the nail plate.[3,6]

**Covered Indications**

Avulsion of the nail plate, excision of the nail and nail matrix, and wedge excision of the skin of the nail fold are considered medically reasonable and necessary for the following indications:

1. Symptomatic onychocryptosis (ingrown fingernails or toenails)[1,4,7,8]
2. Subungual abscess and/or hematoma[7,9,10]
3. Subungual and periungual tumors[2,9]
4. Injury of the toes or fingers involving the nail component to evaluate the stability of the nail bed or to release a subungual hematoma after a failed puncture aspiration[1,7,11]
5. Severe or recurrent fungal nail infection that has failed to respond to usual, less invasive treatment (for example, pharmacological treatment, debridement)
6. For diagnosis of suspected lichen planus or psoriasis of the fingernail or toenail[2, 9,10]
7. Onychogryphosis or onychauxis[1]
8. Congenital or acquired nail dystrophies that jeopardize the integrity of the finger or toe[1,2,10]

**Limitations**

The following are considered not medically reasonable and necessary:

1. Nail debridement or removing small chips or wedges of the nail and/or skin that does not require local anesthesia does not constitute surgical treatment of a nail[3,6,11]
2. Trimming, cutting, or clipping of the distal unattached nail margins does not constitute surgical treatment of a nail[3,6,11]
3. Surgical treatment of asymptomatic conditions[3,6]
4. Repeat nail avulsion on the same toe or finger following a complete nail avulsion performed more frequently than every 8 months (32 weeks) for toenails or 4 months (16 weeks) for fingernails[7,10]
5. Repeat nail excision on the same toe or finger following a complete nail excision for permanent removal

**Provider Qualifications**

Services will be considered medically reasonable and necessary when all aspects of care are within the scope of practice of the provider's professional licensure, when performed according to the supervision requirements per state scope of practice laws, and when all procedures are performed by appropriately trained providers in the appropriate setting.

**Notice**: Services performed for any given diagnosis must meet all of the indications and limitations stated in this LCD, the general requirements for medical necessity as stated in CMS payment policy

manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

## Summary of Evidence

The content of this LCD is supported through an evidence-based literature search of articles and publications through PubMed. Articles were identified based on a key word search for: indications for the surgical treatment of nails, ingrown toenails. The literature search was filtered to find articles within 5 to 10 years. Also included were full text articles, clinical trials, randomized controlled trials, and systematic reviews. Below is a summary of evidence to support the medically reasonable and necessary indications for the surgical treatment of nails and explanation of limitations.

Yaemsiri et al conducted a study of human nail clippings for epidemiological studies as a biomarker for assessing diet and environmental exposure to trace elements or other chemical compounds. To the authors knowledge at the time of this study, little was known about toenail and fingernail growth rates so the purpose of the study was to estimate the average growth rate of fingernails and toenails and to examine factors that may influence nail growth rate. Study participants were twenty-two healthy American young adults. The participants marked their nails close to the proximal nail fold with a provided nail file using a standardized protocol. Participants recorded the date and distance from the proximal nail fold to the mark at one to three months with the average time frame between baseline and final measurement as 64 days (range: 33 to 89 days). Nail growth was calculated based on the study participants recorded distance and time between the measurements of date and the distance from the proximal nail fold to the mark. The results were reported in millimeters per month, a month was defined as 30 days. Information was obtained on the nail growth rate of 195 fingernails and 188 toenails from twenty-two participants. With this study, it was observed that the “average fingernail growth rate 3.47 mm/month) was over twice as fast as that of toenails (1.62 mm/month), $P < 0.01$.” Also, it was determined that, “Younger age, male gender, and onychophagia were associated with faster nail growth rate; however, the differences were not statistically significant.”[12] There were some limitations noted. Study participants were young adults and therefore results were not generalizable to children or the elderly. Another limitation was that, as shown in previous studies, nail growth rate may be modified by other factors such as race, pregnancy, and disease status. Additionally, the small sample size limited the ability to measure the differences in factors noted above and nail growth rate based on self-measurements may have inherent errors. Lastly, follow-up time was short and limited the ability to determine the possible variation in nail growth rate across seasons and climates as compared in previous studies.

Eekhof et al updated the Cochrane review 'Surgical treatments for ingrowing toenails.' Two authors independently selected studies that included randomized control trials (RCT) of non-surgical and surgical interventions for ingrowing toenails. Search of the databases to January 2010 included Cochrane Skin Group Specialized Register, CENTRAL in The Cochrane Library, MEDLINE, and EMBASE. In addition, searches of CINAHL, WEB of SCIENCE, ongoing trials databases, and the reference articles were updated. Methodological quality, and data were extracted from the selected studies. This update included 24 RCT studies, with a total of 2,826 participants, 7 of the studies were included in the previous review. Five studies were on non-surgical interventions, and 19 were on surgical interventions.

The comparison of non-surgical interventions with surgical interventions revealed that surgical interventions are more effective in preventing the recurrence of an ingrowing toenail and surgical interventions are most likely to be of use when the ingrowing toenail is at a more severe stage of

development (stage II and stage III). In the studies comparing a surgical intervention to a surgical intervention with the application of phenol, (phenolization), authors determined that the addition of phenol is probably more effective in preventing recurrence and regrowth of the ingrowing toenail.[11] One limitation noted is there is only one study in which the surgical interventions in both study arms were equal, thereby more studies must be done to confirm these outcomes. Also, although there are different non-surgical and surgical interventions for ingrowing toenails that are available, there is no agreement about a standard first choice treatment.

The recurrence rate, for ingrown toenail, with a simple partial nail avulsion is approximately 70 percent.[8] A study by Khan et al revealed that at follow-up at one and six months 5% of the patients had spike formation and all of them belonged to the partial nail avulsion alone group. Between the groups studied, patients with surgery with phenolization and patients without phenolization, the p-value for recurrent disease was 0.027 considered significant and showed that partial avulsion with phenol application had better outcome compared to partial nail avulsion without the application of phenol.[13] Other studies have shown that the surgical technique of partial lateral nail avulsion and matrixectomy has been shown to achieve success in the treatment of ingrown nails.[14]

Avulsion of the nail plate may be initially performed to allow full exposure of the nail matrix to visualize the nail bed and nail matrix in order to look for pathologies originating in either the nail bed or the nail matrix, which may include inflammatory dermatoses, (e.g., chronic plaque psoriasis), infections, connective tissue diseases (e.g., systemic sclerosis, lupus erythematosus (SLE), dermatomyositis (DM), primary Sjogren's syndrome), and tumors.[1] Avulsion of the nail plate may also be performed in order to obtain a biopsy on the nail bed or matrix for diseases with nail deformities associated with dermatologic conditions, like psoriasis and lichen planus nail dystrophy, as well as, nail unit tumors, nevi, suspected malignant melanoma, longitudinal melanonychia and pachyonychia congenita.[2,7,9,10] Total nail avulsion is a method to examine and treat various nail unit pathologies; (Chronic onychomycosis and periungual warts) however, the literature notes that partial avulsion procedure, due to its simplicity and fewer postoperative complications, is often found to be preferred. Also noted, careful patient selection and maintenance of asepsis during and after the procedure and gentle handling of the matrix and nail folds are noted to promote positive outcomes of the procedure. Nail generation depends on a patient's age, gender, and habits. Complete regrowth of an avulsed fingernail usually requires 4 to 5 months, whereas the toenail may require up to 10 to 12 months.[7,10]

A partial nail avulsion, used to treat a symptomatic infected ingrown toenail is a temporary relief for ingrown toenails as the nail matrix often grows back to its original thickness and the offending margin may again become a problem, resulting in another ingrown nail. When a nail avulsion is done, the matrix is not typically destroyed, thus leading to regrowth of the spicule or nail plate.[13,14] For those patients who have failed conservative therapy or have a symptomatic presentation of an ingrown toenail that is moderate to severe[3]; a surgical intervention such as removal of granulation tissue of the affected nail fold and a partial nail avulsion of the affected nail edge and with the application of a chemical, surgical, or electrocautery matrixectomy to prevent recurrences, may be required.[13] A Cochrane systematic review found that a partial nail avulsion combined with phenolization is more effective at preventing symptomatic recurrence of an ingrown nail than surgical excision/removal without phenolization (one in 25 patients with recurrence versus eight in 21 without phenolization).[11] In a 2019 publication, the American Academy of Family Physicians reported that matrixectomy prevents recurrence of an ingrown nail and can be performed through surgical, chemical, or electrosurgical means.

The American Academy of Dermatology (AAD) Association Administrative Regulations for Evidence-

based Clinical Practice Guidelines addresses the safety of the clinical use of some of the more commonly used local anesthetics (i.e., topical, infiltrative, nerve blocks, and infiltrative tumescent) in dermatologic surgeries in the office setting. One hundred sixty-five abstracts were retained and used. A secondary manual search identified 36 additional relevant studies. Once the full data set of 201 studies was made in proper order and categorized, each study was reviewed and ranked based on relevance, then the level of evidence for the clinical questions were determined by the workgroup.

Clinical recommendations per the workgroup were developed based on the best available evidence. The strength of recommendation was ranked as A, B, or C. Where documented evidence-based data were not available, or showed inconsistent or limited conclusion, expert opinion and medical consensus were also considered.[15]

This study supports the recommendations for the use of topical anesthesia in dermatologic surgery. Infiltrative anesthesia is considered safe and recommended for office-based dermatologic procedures, including but not limited to obtaining a biopsy specimen, excision, wound closure, tissue rearrangement, skin grafting, cauterization, nonablative laser, and ablative skin resurfacing is a strength of recommendation of “C” and a level of evidence of “III” referenced by expert opinion.[15]

Nail trephination or releasing the hematoma is a technique to relieve painful pressure by draining the blood beneath the nail. Onumah et al describes the management of subungual hematomas which depends on their size, location, and presentation. A hematoma that occupies 25% or more of the nail bed is evacuated by creating one or two small puncture holes through the nail plate, to allow drainage of the hematoma.[7] Tos et al describe strategies in treating nail bed and fingertip injuries. If the hematoma is 50% or more of the underlying nail area, depending on the type and degree of injury, the nail plate may need to be surgically removed. When there is greater than 50% involvement of the nail plate and associated fracture of the distal phalanx, the authors suggest the examination of the complete nail bed. Although studies show that it may be necessary to have the nail removed to examine the nail bed for injury, and subsequent repair, the authors noted that this is no longer a routine practice if the nail edges or margins are intact.

## Analysis of Evidence (Rationale for Determination)

Partial or complete avulsion of the nail plate with the use of a local anesthetic may be performed to allow the exposure of the nail matrix for examination of the nail bed enabling visualization of the nail bed and nail matrix in order to look for pathologies originating in either the nail bed or the nail matrix. Studies have shown that partial or complete nail avulsion is considered medically reasonable and necessary for the examination of the nail bed and for the treatment of traumatic nail injury, subungual abscess and/or hematoma, subungual tumors, onychogryphosis, onychauxis, onycholysis, symptomatic congenital nail dystrophies or nail deformities associated with dermatologic conditions. Studies have shown that complete regrowth of an avulsed fingernail usually requires 4 to 5 months, and the toenail may require up to 8 to 12 months. Based on these studies, a repeat nail avulsion on the same toe or finger following a complete nail avulsion performed more frequently than every 8 months (32 weeks) for toenails or 4 months (16 weeks) for fingernails is considered not medically reasonable and necessary.

For those patients who have failed conservative therapy or have a symptomatic presentation of an ingrown toenail that is too severe for a non-surgical intervention, a surgical intervention, such as removal of granulation tissue of the affected nail fold and a partial nail avulsion of the affected nail edge either with or without the application of a chemical, surgical, or electrocautery matrixectomy may

be considered medically reasonable and necessary for the treatment of a symptomatic ingrown toenail or fingernail.

## General Information

### Associated Information

Please refer to the related Local Coverage Article: Billing and Coding: Surgical Treatment of Nails A57666 for documentation requirements, utilization parameters and all coding information as applicable.

### Sources of Information

Novitas Solutions JH LCD L32637, Nail Avulsion
Other Contractor's Policies
Contractor Medical Directors

### Bibliography

### Use the following link to obtain the complete LCD:

**https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33833&ver=20**

**b)**

**Article:**

# Billing and Coding: Surgical Treatment of Nails

**A57666**

Expand All | Collapse All

## Contractor Information
## Article Information

General Information
**Article ID**
A57666
**Article Title**
Billing and Coding: Surgical Treatment of Nails
**Article Type**
Billing and Coding
**Original Effective Date**
10/03/2018

**Revision Effective Date**
01/30/2022
**Revision Ending Date**
N/A
**Retirement Date**
N/A
**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**



## CMS National Coverage Policy

**Internet-Only Manuals (IOMs)**

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
    - Chapter 23, Section 20.9 National Correct Coding Initiative (CCI)

**National Correct Coding Initiative Edits**

- *National Correct Coding Initiative (NCCI) Policy Manual for Medicare*,
    - Chapter 1 General Correct Coding Policies For National Correct Coding Initiative Policy Manual for Medicare Services
    - Chapter 3 Surgery: Integumentary System CPT codes 10000-19999 For National Correct Coding Initiative Policy Manual for Medicare Services

**Social Security Act (Title XVIII) Standard References:**

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

## Article Guidance

### Article Text

This Billing and Coding Article provides billing and coding guidance for Local Coverage Determination (LCD) L33833 Surgical Treatment of Nails. Please refer to the LCD for reasonable and necessary requirements.

**Coding Guidelines**

**Notice**: It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

The description of CPT codes 11730, 11732 and 11750 indicates partial or complete avulsion or excision of a nail plate. When CPT code 11730, 11732 or 11750 is reported, it represents all services performed on that nail for that date of service (DOS). When lateral and medial sides of a nail are involved, do not report a separate code for each border.

Procedure code 11750 (Excision of nail and nail matrix, partial or complete, [e.g., ingrown or deformed nail] for permanent removal) requires the removal of the full length or the entire nail plate, with destruction or permanent removal of the matrix by any means.

Reporting CPT codes 11730 or 11732 (avulsion) with CPT code 11750 (excision) and or 11765 (wedge resection) for the same digit on the same DOS is not correct coding.

Reporting CPT code 11750 (excision) with CPT code 11765 (wedge resection) for the same digit on the same DOS is not correct coding.

CPT code 11765 requires an excision of a wedge of the skin of the nail fold from the involved side of the toe. Reporting CPT code 11765 for the removal of a small piece of the skin and/or the nail without local anesthesia is not correct coding.

Procedure code 11730 (Avulsion of nail plate, partial or complete, simple; single) is reported when removing part of the nail plate or the entire nail plate.

Claims must include the nail on which the procedure is performed using one of the modifiers listed in the Coding Information section below to identify the digit in order for payment to be considered.

For services performed on different nails:

- If CPT procedure codes 11730, 11750, or 11765 are performed on different nails, report the procedure performed with one unit of service (UOS) and append with the appropriate identifying digit modifiers.
- For every subsequent avulsion, CPT 11732 is reported as the add-on code with one UOS and the appropriate identifying digit modifier appended.

**Utilization Parameters**

CPT codes 11730 and 11732 for nail avulsion will be denied if billed for the same finger less than 4 months (16 weeks) or the same toe less than 8 months (32 weeks) following a previous avulsion.

For a medically necessary repeat nail avulsion on the same finger less than 4 months (16 weeks) or the same toe less than 8 months (32 weeks) following a previous avulsion, use modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or modifier 77 (repeat procedure by another physician or other qualified health care professional). The medical record documentation must be specific as to the indication, such as ingrown nail of the opposite border or new significant pathology on the same border recently treated.

CPT code 11750 for nail excision permanent removal will be denied if billed for the same finger or toe following a previous excision.

For a medically necessary repeat nail excision on the same finger or toe, use modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or modifier 77 (repeat procedure by another physician or other qualified health care professional). The medical record documentation must be specific as to the indication, such as ingrown nail of the opposite border or new significant pathology on the same border recently treated.

Compliance with the use of modifier 76 and modifier 77 may be monitored and addressed through post payment data analysis and subsequent medical review audits.

**Documentation Requirements**

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The following information must be clearly documented in the patient’s medical record:
    - Complete detailed description of the pre-operative findings. Include the patient’s symptoms, the physical examination documenting the severity of the nail infection, injury or deformity, and the assessment and plan containing the rationale why surgical treatment is being selected over other treatment options.
    - Method of obtaining anesthesia (if not used, the reason for not using it).
    - A complete detailed description of the procedure performed.

- Identify the specific digit(s) and make note to the nail margin(s) involved on which the procedure was performed.
- Postoperative observation and treatment of the surgical site (e.g., minimal bleeding, sterile dressing applied).
- Postoperative instructions given to the patient and any follow-up care (e.g., soaks, antibiotics, follow-up appointments).

# Coding Information

## CPT/HCPCS Codes

Expand All | Collapse All

### Group 1

(4 Codes)

#### Group 1 Paragraph

Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

#### Group 1 Codes

| Code | Description |
|---|---|
| 11730 | Removal of nail plate |
| 11732 | Remove nail plate add-on |
| 11750 | Removal of nail bed |
| 11765 | Excision of nail fold toe |

## CPT/HCPCS Modifiers

Expand All | Collapse All

### Group 1

(22 Codes)

#### Group 1 Paragraph

N/A

#### Group 1 Codes

| Code | Description |
|---|---|
| 76 | REPEAT PROCEDURE BY SAME PHYSICIAN: THE PHYSICIAN MAY NEED TO INDICATE THAT A PROCEDURE OR SERVICE WAS REPEATED SUBSEQUENT TO THE ORIGINAL PROCEDURE OR SERVICE. THIS CIRCUMSTANCE MAY BE REPORTED BY ADDING THE MODIFIER -76 TO THE REPEATED PROCEDURE OR SERVICE OR THE SEPARATE FIVE DIGIT MODIFIER CODE 09976 MAY BE USED. |

| Code | Description |
|---|---|
| 77 | REPEAT PROCEDURE BY ANOTHER PHYSICIAN: THE PHYSICIAN MAY NEED TO INDICATE THAT A BASIC PROCEDURE OR SERVICE PERFORMED BY ANOTHER PHYSICIAN HAD TO BE REPEATED. THIS SITUATION MAY BE REPORTED BY ADDING MODIFIER -77 TO THE REPEATED PROCEDURE/SERVICE OR THE SEPARATE FIVE DIGIT MODIFIER CODE 09977 MAY BE USED. |
| F1 | LEFT HAND, SECOND DIGIT |
| F2 | LEFT HAND, THIRD DIGIT |
| F3 | LEFT HAND, FOURTH DIGIT |
| F4 | LEFT HAND, FIFTH DIGIT |
| F5 | RIGHT HAND, THUMB |
| F6 | RIGHT HAND, SECOND DIGIT |
| F7 | RIGHT HAND, THIRD DIGIT |
| F8 | RIGHT HAND, FOURTH DIGIT |
| F9 | RIGHT HAND, FIFTH DIGIT |
| FA | LEFT HAND, THUMB |
| T1 | LEFT FOOT, SECOND DIGIT |
| T2 | LEFT FOOT, THIRD DIGIT |
| T3 | LEFT FOOT, FOURTH DIGIT |
| T4 | LEFT FOOT, FIFTH DIGIT |
| T5 | RIGHT FOOT, GREAT TOE |
| T6 | RIGHT FOOT, SECOND DIGIT |
| T7 | RIGHT FOOT, THIRD DIGIT |
| T8 | RIGHT FOOT, FOURTH DIGIT |
| T9 | RIGHT FOOT, FIFTH DIGIT |
| TA | LEFT FOOT, GREAT TOE |

## ICD-10-CM Codes that Support Medical Necessity

Expand All | Collapse All

### Group 1

(392 Codes)

#### Group 1 Paragraph

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

The following ICD-10-CM codes support medical necessity and provide coverage for **CPT codes: 11730, 11732, 11750, and 11765:**

### Group 1 Codes

| Code | Description |
|---|---|
| B35.1 | Tinea unguium |
| I96 | Gangrene, not elsewhere classified |
| L03.011 | Cellulitis of right finger |
| L03.012 | Cellulitis of left finger |
| L03.031 | Cellulitis of right toe |
| L03.032 | Cellulitis of left toe |

**Due to the number of pages containing all of the codes in the Article, I have only provided a brief list.**

**You can utilize the following link to obtain a complete list of codes and the article in its entirety:**

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57666&ver=15

**c)**

**The following should have been received by all members last December. I had submitted to provide an update regarding the "Surgical Treatment of Nails" LCD/Article.**

FPMA
FLORIDA PODIATRIC MEDICAL ASSOCIATION

# FPMA Insurance Alert

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December 21, 2021

To FPMA Membership:

FCSO has just posted the long-awaited finalized LCD and Article for "Surgical Treatment of Nails".

In summary, as the FCSO CAC representative, I provided in writing a number of recommendations and suggested changes to the policy several months prior (during the draft process). In addition, I verbalized concerns with FCSO via a webinar. I also provided supportive arguments to justify changes prior to the finalized version.

The updated policy is not effective until January, 2022. For those that utilize these codes, I suggest reading the LCD and Article to better understand the changes.

Probably the most significant change addresses the frequency of performing these procedures. Be aware of the 8-month window. However, the carrier states that under certain circumstances, exceptions may be considered.

It is my understanding that APMA will shortly provide additional information, since a similar policy is applicable for Novitas (another major Medicare carrier). Rather than providing duplicate information, I will wait for their posting.

Should additional clarification be required, I will follow up with membership. I intend to speak further on this policy, if needed, as I delve into some of the fine points. In addition, I will reach out to my sources at FCSO, if required.

To assist the membership, I have provided links to the LCD and Article below:

**https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33833&ver=20**

**https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57666&ver=15**

Wishing everyone safe Happy Holidays and a Happy New Year.

Fraternally,

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair, FPMA Insurance Committee
FPMA Medicare CAC/PIAC Representative

**d)**

## APMA publication offering guidance.

New Guidance on Surgical Treatment of Nails for Those Who Serve Novitas and First Coast Beneficiaries

December 20, 2021

Medicare Contractors Novitas and First Coast Services released identical policies that take effect January 30, 2022. The policies state: 1. Providers must document which nail borders are addressed when surgical treatment of nails is performed.

2. When surgical procedures (CPT 11730, 11732, 11750, 11765) are performed on the medial and lateral borders of the same toenail, a separate code should not be submitted for each border.

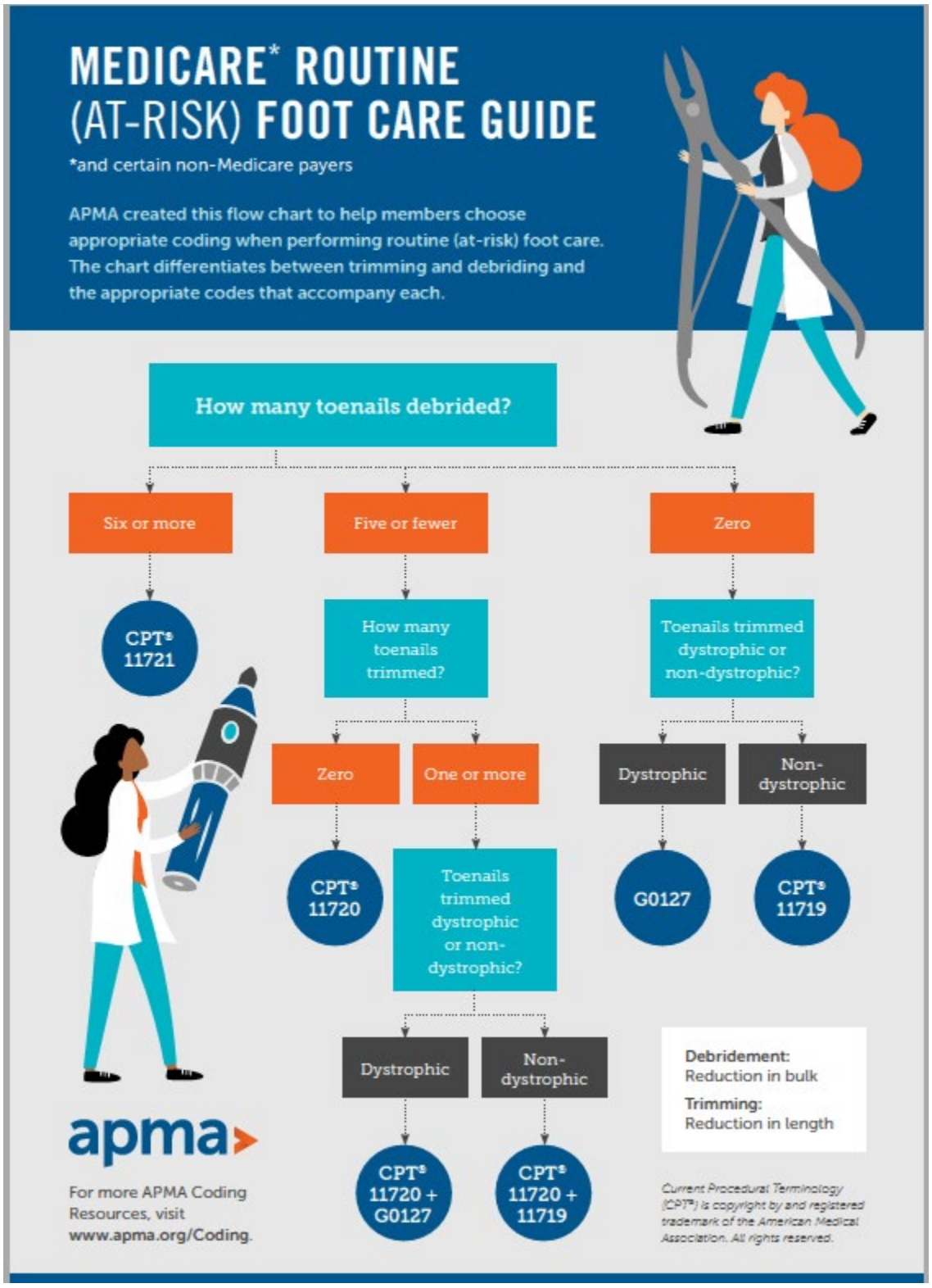
3. A repeat nail avulsion on the same toe less than eight months following a previous avulsion is allowed if the ingrown nail affects the opposite border of the one recently treated or there is new, significant pathology affecting the same border recently treated. When this occurs, Modifier 76 (repeat procedure or service by the same physician or other qualified health-care professional) or Modifier 77 (repeat procedure by another physician or other qualified health-care professional) should be appended.

4. A repeat nail excision (CPT 11750) of the same toe is allowed if the procedure involves the opposite border of the one already excised or there is new, significant pathology affecting the same border already treated. When this occurs, Modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or Modifier 77 (repeat procedure by another physician or other qualified health-care professional) should be appended.

When these policies were first proposed, repeat nail avulsion on the same toe less than eight months following a previous avulsion and repeat nail excision of the same toe were to be never allowed. Those proposed limitations were amended to what is listed above following advocacy led by APMA. Further Reading: Surgical Treatment of Nails (L34887) Billing and Coding: Surgical Treatment of Nails (A52998

**4)**

**The following pictogram is available as a helpful tool to all APMA members. A copy can also be obtained via the APMA members-only website (www.apma.org\Coding).**



**5)**

## APMA CAC Meeting November 2021

## Last Fall, APMA had their annual CAC meeting in Alexandria, Virginia. The following contains some of the significant issues discussed and shared with me and other attendees from the state components. For those interested, additional topics and material related to this meeting can be accessed via the APMA members-only website.

**"21st Annual Joint National Podiatric CAC-PIAC Representatives' Meeting**

I recently attended the 21st Annual Joint National Podiatric Carrier Advisory Committee (CAC)-Private Insurance Advisory Committee (PIAC) Representatives' Meeting, held in-person and virtually on November 12, 2021, on behalf of our association. The meeting featured experts and leaders on both private and public insurance issues, as well as opportunity to hear from our colleagues around the country and discuss new and ongoing trends and challenges that might impact our members.

Attendees were first updated on the CY 2022 Medicare Physician Fee Schedule Final Rule from Cindy Moon, MPP, MPH, vice president at Hart Health Strategies and APMA Health Policy and Practice Consultant Jeff Lehrman, DPM. Of significant concern to members is the possible up to 9.75 percent reductions to Medicare provider reimbursement for 2022, due to expiration of the temporary increase for 2021, the Medicare sequester reductions that were suspended for COVID-19, and the PAYGO sequester reductions. Significant advocacy is underway to avert these reductions, including an APMA eAdvocacy campaign for members and APMA working with other stakeholders to lobby Congress and CMS to avert these reductions. Write to Congress to at www.apma.org/eAdvocacy.

Additionally, the final conversion factor is 33.5983. The estimated impact on podiatrists for 2022 not including scheduled payment reductions is +1 percent. CMS also finalized the following changes:

- Retain all Category 3 services on the Medicare telehealth services list through December 31, 2023;
- Allow physician assistants bill directly for services they perform, as required under law; and
- Delay onset of AUC penalties until January 1, 2023 or the January 1 that follows the end of the Public Health Emergency, whichever is later.

Members can learn more at www.apma.org/Medicare.

APMA private insurance consultant Kelli Back, Esq., also updated attendees on ongoing issues for Medicare Advantage and commercial plans. She noted the following key highlights:

- No Surprises Act: Ensures patients are not obligated to pay more than the in-network cost sharing under their commercial health plan in certain situations when out-of-network providers furnish services and sets forth a process for non-contract providers and insurers to come to agreement on payment amounts. This will be effective January 1, 2022. Learn more about the No Surprises Act on January 11, 2022 in a Webinar hosted by APMA. Register at www.apma.org/Webinars.
- Medicare Advantage continues to be problematic for providers with onerous record requests and frequent denials. APMA and other medical specialty societies recently met with CMS to address member concerns.
- Ms. Back also reminded attendees that Advanced Beneficiary Notices (ABN) are not appropriate for use with Medicare Advantage plans and should only be used with Medicare Fee-For-Service.

Given that record requests are one of the biggest sources of headaches for our members, Ms. Back spent a good amount of time reviewing the reasons for data mining and what providers can do when they receive onerous record requests. She also reviewed the significant advocacy work that APMA has done and will continue to do on behalf of APMA members to resolve this burden Members can learn more about responding to Medicare Advantage Record Requests in the July/August issue of APMA News or log on to www.apma.org/MedicareAdvantage.

Attendees also heard directly from and were able to pose questions to two Noridian carrier medical directors (CMDs), Gary Oakes, MD, and Larry Clark, MD. Drs. Oakes and Clark addressed member questions about the LCD process and development changes, concerns about amniotic injection denials, and other critical CAC concerns.

Health Policy and Practice Chair Ed Prikaszczikow, DPM spent time addressing best practices for CAC and PIAC representatives. Some of Dr. Prikaszczikow' s advice is also relevant to every member, such as:

- Know the Medicare Program Integrity Manual and understanding the Local Coverage Determination and Local Coverage Article Process
- Use APMA resources and communicate with both APMA and your state association regularly
- Stay in the know by subscribing to private and public payer newsletters.

Ross Taubman, DPM, President and Chief of Medical Officer of PICA, addressed how members can benefit from administrative defense coverage (ADC), via PICA or another medical malpractice carrier. ADC can be used to help with coding and billing audits from both public

and private payers, state board investigations whether related or unrelated to a malpractice claim, decertification from an insurance plan, and more.

He covered how important it is to know how your billing compares to your peers in a region or nationally, having competent and well-trained billing staff is, and that all providers should implement and follow good, written corporate compliance and documentation practices.

Finally, as in years past, attendees spent time discussing regional concerns in both the public and private insurance spheres. This key feature allows representatives to share experiences and collaborate on solutions to common issues. In the public insurance arena, the biggest areas of concern are the continued DME same and similar denials, coverage for wound care, and amniotic injections/skin substitutes. For private payers, bundling and reimbursement issues for Medicare Advantage versus Original Medicare, denials or reimbursement reduction for claims billed with the -59 or -25 modifiers, DME audits, prior authorizations, and record requests.

During the meeting, Iowa CAC Rep Theresa Hughes, DPM, was recognized as the "CAC-PIAC Rising Star of the Year." She was also elected to serve as APMA's new CAC Chair. Tennessee CAC Rep Ira Kraus, DPM was recognized as "CAC-PIAC Representative of the Year." More information on is available at www.apma.org/CACPIAC2021."

**Although not a complete list, I am providing some topics that I felt were a priority. However, members may find additional information that fits their practice needs at the noted APMA members site.**

## a)

## The APMA consultants shared the following:

Under current law, payments to physicians under the Medicare Physician Fee Schedule (MPFS) are scheduled to be reduced by up to 9.75 percent for 2022: – 3.75% Expiration of a temporary increase in MPFS for 2021 only (MPFS only)

– 2% Medicare sequester reductions that were suspended for the COVID-19 PHE but scheduled to resume on January 1, 2022 (all Medicare providers)

– 4% PAYGO sequester reductions that are triggered by spending in the American Rescue Plan that was not offset (all Medicare providers)

• Significant advocacy is underway to avert these reductions, but uncertainty remains

## b)

**Final 2022 Conversion Factor**: 33.5983

– 3.71% less than 2021, almost fully due to expiration of temporary increase for 2021

• **Estimated impact on podiatrists for 2021 not including scheduled payment reductions: +1%**

## c)

• CMS finalized its proposal to implement another provision from the Consolidated Appropriations Act, 2021, which authorizes PAs to bill Medicare and be directly paid for their services starting January 1, 2022.

– Eliminates requirement for payment to go to the employer of the PA, as required by law

## d)

## AUC

Appropriate Use Criteria for Advanced Diagnostic Imaging

Penalty Phase Delayed to 1-1-23 or the January 1 that follows the end of the PHE

Additional details can be accessed at: APMA.org/AUC

## e)

• APMA continues to have concerns regarding local coverage processes:

– Lack of notice and comment opportunities for LCAs

– Limited engagement with CACs

– Lack of transparency in coverage processes

• APMA will be launching a sign-on letter to raise concerns with CMS collectively with other likeminded stakeholders.

**f)**

• APMA has partnered with several other organizations to address concerns members have raised regarding MA chart reviews.

– Sign-on letter in February 2021

– Joint meeting with CMS last month

• Additional engagement continues.

**g)**

**PICA Presentation**

**The following are excerpts from the PICA presentation.**

**Podiatry has, and continues to be, a highly audited medical specialty.**

**Most Commonly Audited Codes**

**11720/11721 (nail debridement)**

 Mycotic nail coverage rules

 Covered routine foot care

**E/M Codes with -25 modifier**

 Significant, separately identifiable E/M service = subjectivity

**Wound Care Codes**

**Injection codes**

**11060/11061 (I&D Abscess)**

**11050 series (corns/calluses)**

**59 Modifier**

**Orthotic Codes13**

**Medicare Appeal Process**

| Level | Type of Appeal | Time Limit |
|---|---|---|
| 1st | Redetermination | 120 days |
| 2nd | Reconsideration (QIC) | 180 days |
| 3rd | Administrative Law Judge | 60 days |
| 4th | Medicare Appeals Council | 60 days |
| 5th | Federal District Court | 60 days |

**The mere fact that you billed for a code for many years (and have been paid) does not mean you are billing correctly.**

**A Word About State Board Investigations**

**Fines/penalties**

**Payment for education**

**Time away from office**

**Loss of reputation**

**Decree of Censure**

**Probation**

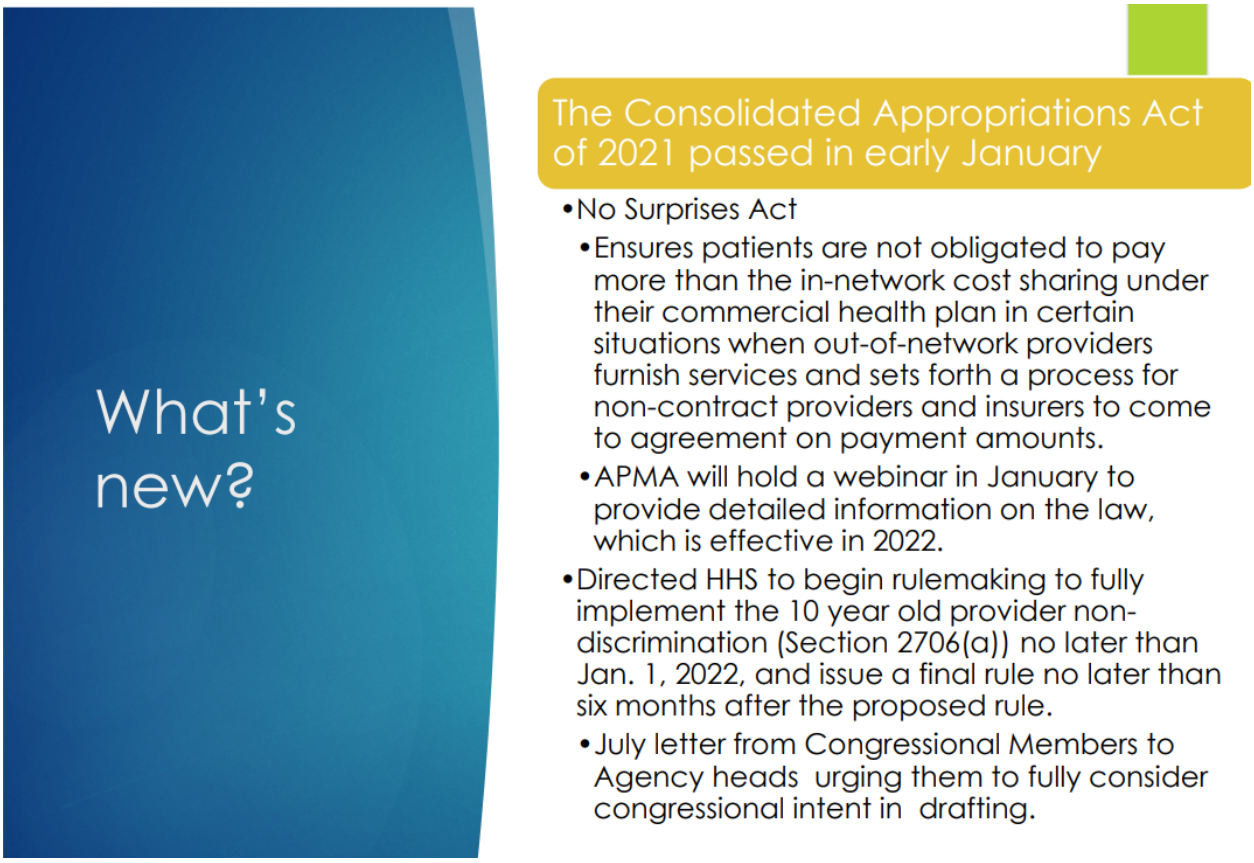
**Suspension of license**

**Revocation of license**

**h)**

**Kelli Back, a healthcare attorney and consultant for APMA, gave the following presentation. Excerpts from this presentation are noted below. Additional information is available on the APMA website.**

## Private Insurance Issues



# Medicare Advantage Market Snapshot

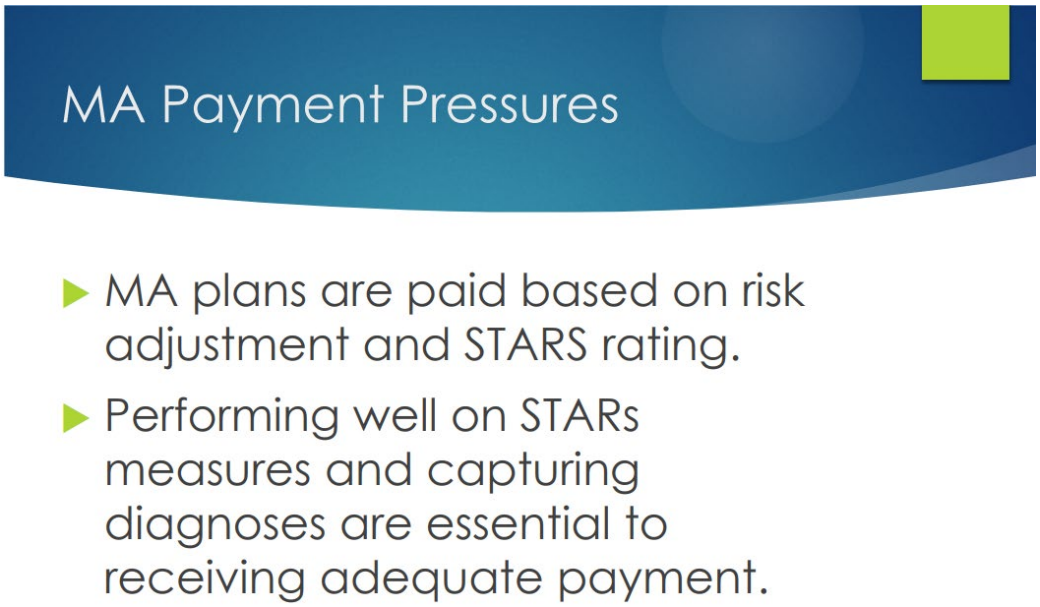
- 26.4 Million beneficiaries were enrolled in MA plans for 2021 or 42 percent of Medicare beneficiaries. This is projected to increase to over 50% by 2030.
- For 2022, 20 new organizations obtained Medicare Advantage contracts. Thirteen will offer generally available plans, the rest will offer special needs plans.
- The average beneficiary can choose from plans offered by 9 different organizations, and 99% have at least one MA plan available in their area.
- For 2022, 3,834 MA plans are available. The most growth was in Florida and Texas.
- Special Needs Plans (SNPs) grew by 17% with the largest area of growth in institutional SNPs.

# Medicare Advantage Market Snapshot

- UnitedHealthcare, Humana, Blue Cross Blue Shield (BCBS) affiliated plans, Aetna (now owned by CVS Health) and Kaiser Permanente account for more than 75% of the market.
- United Healthcare is the biggest with 27%, followed by Humana with 18%.
- Centene had 4% of the market in 2021, but for 2022 has increased its service area by almost 400 counties.
- United has increased its service area by 259 counties in 2022.

**On numerous occasions, I have been approached by members regarding record requests. The following slide contains information relating to this issue.**


**Risk adjustment, noted below, is likely the reason for record requests when occurring annually. These have become a common occurrence for MA providers.**



# Risk Adjustment - Regulatory Authority

"MA organizations must obtain the risk adjustment date required by CMs from the provider, supplier, physician, or other practitioner that furnished the services."

"MA Organizations may include in their contract with providers, suppliers, physicians, and other practitioners, provisions that require submissions of complete and accurate risk adjustment data as required by CMS. The provisions may include financial penalties for failure to submit complete data."

"MA Organizations and their providers and practitioners will be required to submit a sample of medical records for validation of the risk adjustment data as required by CMS."

# Issues with Data Mining

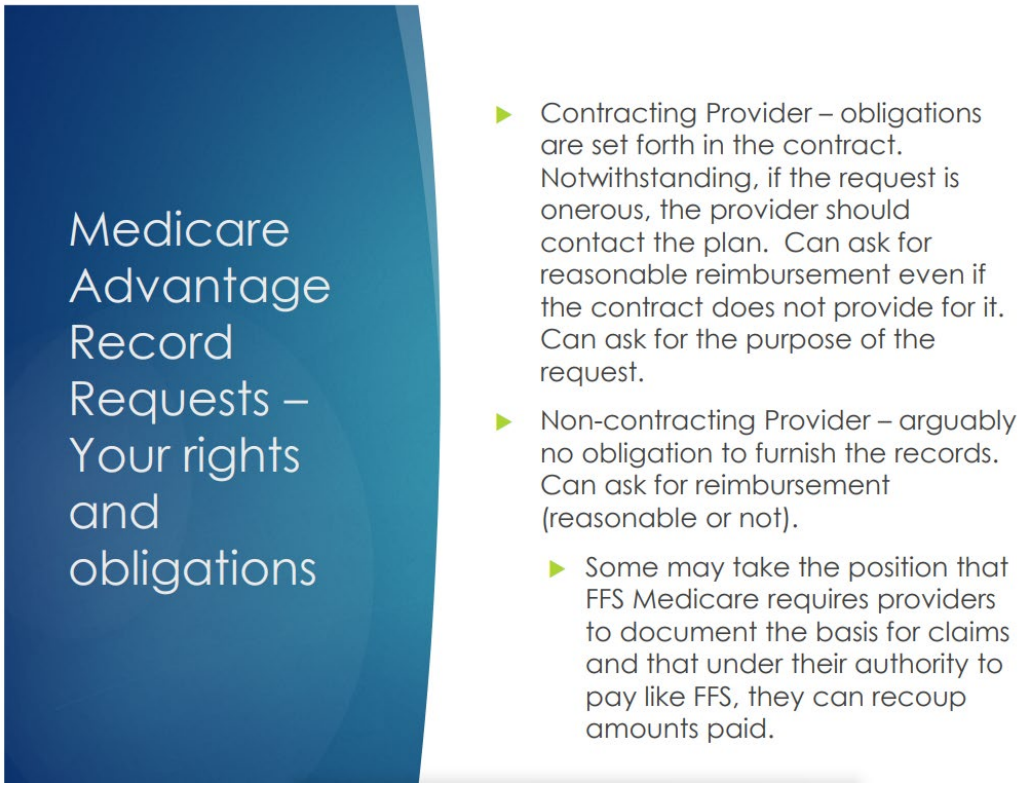
- From 2017 to 2019 CMS successfully pursued false claims charges against multiple plans doing audits that only added diagnoses.
- Plans now must also do audits to confirm diagnoses submitted meet CMS requirements and delete those that do not.
- CMS audits plans to confirm diagnoses submitted meet its requirements and recoups millions. CMS has proposed a controversial rule to allow for extrapolation of findings.
- Dueling pressure to capture diagnoses and ensure compliance with CMS rules has resulted in increased chart reviews

# RADV Checklist

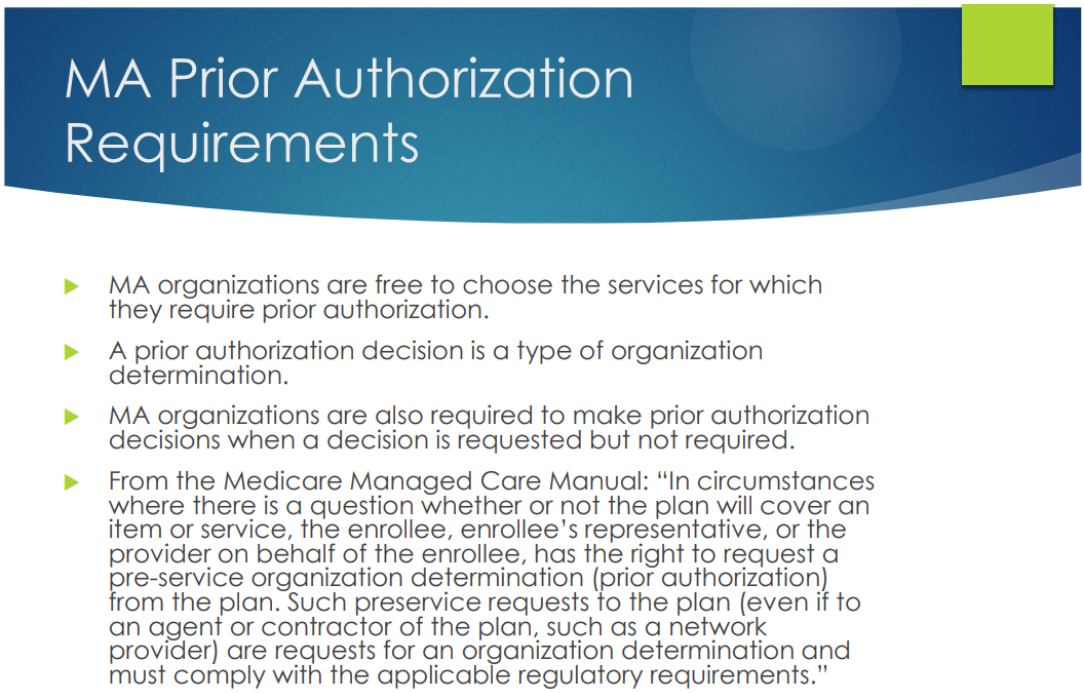
- Is the record for the correct enrollee?
- Is the record from the correct calendar year for the payment year being audited (i.e., for audits of 2013 payments, validating records should be from calendar year 2012)
- Is the date of service present for the face to face visit?
- Is the record legible?
- Is the record from a valid provider type? (Hospital inpatient, hospital outpatient/ physician)
- Are there valid credentials and/or is there a valid physician specialty documented on the record?
- Does the record contain a signature from an acceptable type of physician specialist? If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-Generated Attestation for this date of service?
- Is there a diagnosis on the record?
- Does the diagnosis support an HCC?
- Does the diagnosis support the requested HCC?

# APMA Recommendations

- Follow a standardized process for all medical record requests.
- Require plans to identify the reason for each record request.
- Provide reasonable deadlines for medical record submissions, as well as a process for extending the submission deadline for extenuating circumstances.
- Impose limits on the number of medical records that may be requested or reviewed by an MAO.
- Allow practices to submit medical records through a secure web-portal, on CD/DVD, or by fax, when possible.
- Reimburse practices for completing medical record requests submitted in hard copy.




**As discussed in the slide below, MA plans have latitude regarding prior authorization for specific services.**



# MA Prior Authorization Requirements

- A standard organization determination must be made as quickly as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request.
- An expedited organization determination must be made as quickly as the enrollee's health condition requires but no later than 72 hours after the request.
- For a request made or supported by a physician, the MA organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
- For favorable decisions on a pre-service request, notice may be provided verbally or in writing to the requesting party. Verbal or written notice of a favorable decision must explain any conditions of the approval, such as the duration of the approval. If a provider submits the request on behalf of the enrollee, the MA plan must notify the enrollee as well as the provider of its determination.

# MA Prior Authorization Requirements

- For unfavorable decisions, notice must be given to the requestor and enrollee and must explain the reason for the request.
- Failure to provide the enrollee with timely notice of an organization determination constitutes an adverse organization determination and may be appealed.

# Two Types of Payment Denials

- Denial based on Coverage – remittance notice will indicate the service was not medically necessary or not a covered service.
  - Indicating that a service covered under Medicare FFS is not a covered service may be a compliance issue for the plan.
- Denial in whole or in part based on administrative rule or payment policy – includes situations in which certain modifiers are not recognized or certain services are not paid for the same visit. Generally where plan rules are different than Medicare rules.

# Medicare Advantage - Payment

- Contracted Providers: Paid in accordance with their contract. CMS will generally not get involved in coverage disputes between contracted providers and MAOs. MAOs are not obligated to recognize the same modifiers or otherwise pay in the same manner as FFS if their contract allows it.
  - Contract disputes, however, may be resolved in state courts.
- Non-Contracted Providers: Must generally be paid the same amounts they would have received under FFS Medicare.
  - Certain exceptions for some deemed providers of PFFS plans.

# MA Appeal process

Appeals by Contracted Providers:

- Prior authorization – Regulatory ("member") process (30 days)
- Post-service appeals – Plan Process

Appeals by Non-Contract Providers

- Process specified in regulations, unless – simply a disagreement regarding the amount due for the service. (30 days)

Both:

Expedited Appeals – Regulatory Process - only pre-service appeals (72 hours). Available in situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

# MA Appeal Process

Regulatory Process:

- Organization determination - initial decision on prior authorization (14 days); payment decision on post service claim from non-contract providers (30 days for clean claims)
- Level 1 – Reconsideration – Plan review (30 days or as soon as required by beneficiary health for preservice; 60 days for post-service). If unfavorable in whole or part to provider/member plan must automatically forward to IRE. No action necessary to do level 2 appeal.
- Level 2 – The Part C Independent Review Entity (also called the Part C Qualified Independent Contractor or "Part C QIC"). Overturned cases count against STARS measure.
- Level 3 – Provider or member can appeal to the ALJ.
- Level 4 – Provider, Member or Plan can appeal to Medical Appeals Council.

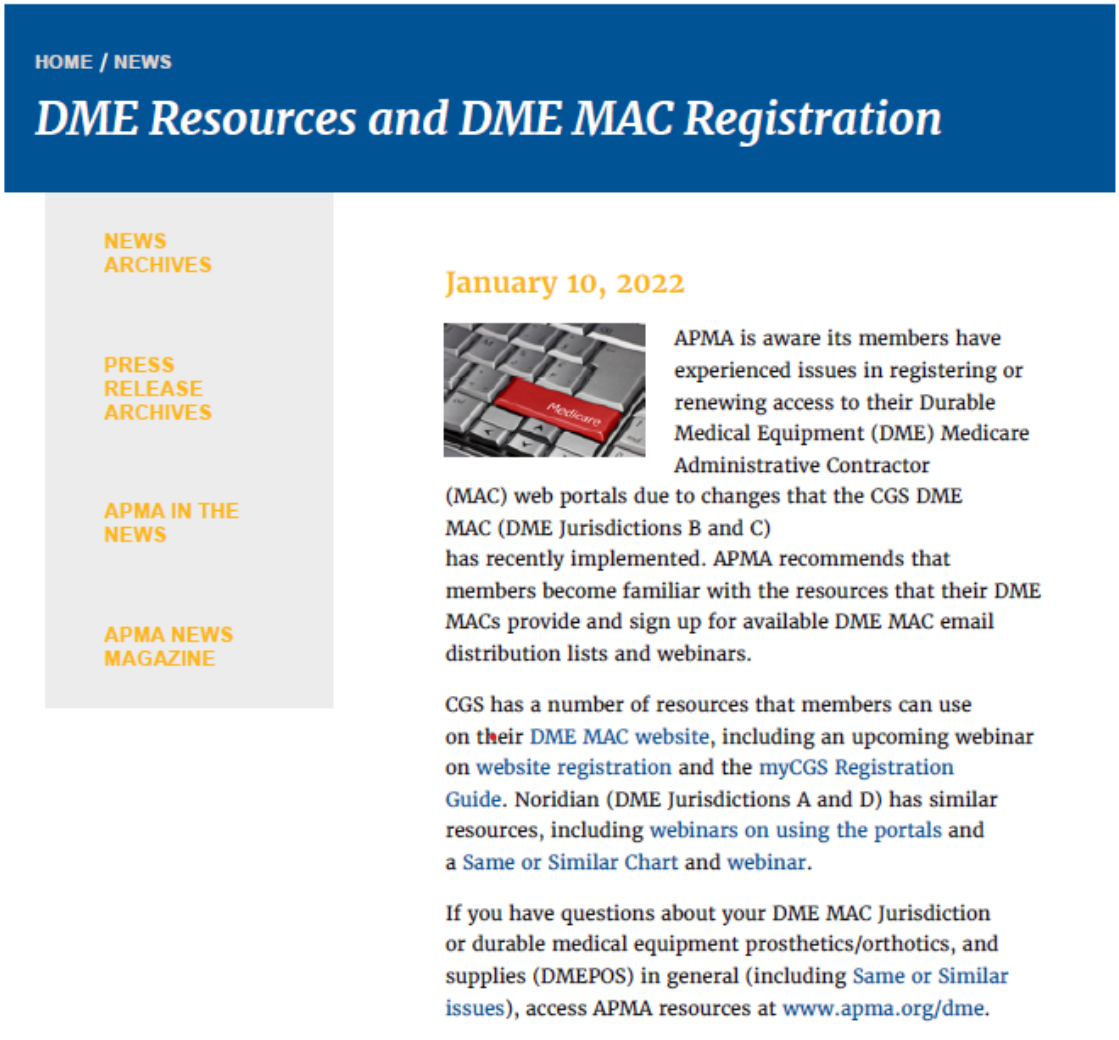
**Additional information on this subject is available by accessing this topic on the APMA website. However, I have attempted to provide and prioritize the material most likely to be of assistance.**

# II

# DME

**1)**

**APMA provided the webinar below in January. The presentation should be accessible through the APMA website.**



HOME / NEWS

## DME Resources and DME MAC Registration

NEWS ARCHIVES

PRESS RELEASE ARCHIVES

APMA IN THE NEWS

APMA NEWS MAGAZINE

January 10, 2022




APMA is aware its members have experienced issues in registering or renewing access to their Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) web portals due to changes that the CGS DME MAC (DME Jurisdictions B and C) has recently implemented. APMA recommends that members become familiar with the resources that their DME MACs provide and sign up for available DME MAC email distribution lists and webinars.

CGS has a number of resources that members can use on their DME MAC website, including an upcoming webinar on website registration and the myCGS Registration Guide. Noridian (DME Jurisdictions A and D) has similar resources, including webinars on using the portals and a Same or Similar Chart and webinar.

If you have questions about your DME MAC Jurisdiction or durable medical equipment prosthetics/orthotics, and supplies (DMEPOS) in general (including Same or Similar issues), access APMA resources at www.apma.org/dme.

**2)**

**DME MAC Jurisdiction C (covers Florida) published a Review Quarterly Report. (For reference purposes, this information can be found by accessing the following link: CGS Administrators, LLC medicareemaillist+cgsadmin.com@ccsend.com)**

**In an effort to assist providers, I read through the communication and have provided four relevant podiatric medicine DME reviews.**

## CGS has posted the JC Medical Review Quarterly Reports by Policy:

**1**

### Ankle-Foot Orthoses (AFO) Post-Pay Review Quarterly Status Report

Analysis of claim denials for AFO HCPCS codes L1902, L1906, L1971, L4396, and L4397 reviewed between July 1, 2021 through September 30, 2021 revealed a denial rate of 23.64%. The top 10 reasons for claim denials are as follows:

*The total percentage will be greater than 100% because some claims were denied for multiple reasons.

| | | |
|---|---|---|
| 1 | Supplier documentation does not include sufficiently detailed description of the modifications necessary at the time of fitting the custom fitted orthosis to the beneficiary. | 40.95% |
| 2 | The medical records do not confirm that the coverage criteria have been met for an orthotic not used during ambulation. | 17.57% |
| 3 | The documentation does not contain a valid Standard Written Order (SWO). Refer to Standard Documentation Requirements A55426 EXT . | 10.54% |
| 4 | The medical records do not confirm that the coverage criteria have been met for an orthotic used during ambulation. | 9.59% |
| 5 | The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met. | 7.43% |
| 6 | The HCPCS procedure code on the claim is not correct for the item(s) billed. | 5.95% |
| 7 | The documentation submitted is incomplete. | 2.43% |
| 8 | The item billed is not specified in the Product Classification List on the Pricing, Data Analysis and Coding (PDAC) contractor website. Refer to applicable Local Coverage Determination/Policy Article. | 1.62% |
| 9 | The file does not contain a valid Advance Beneficiary Notice. See the CGS ABN webpage. | 1.22% |
| 10 | The medical record documentation is illegible. | 0.81% |

**2**

## Orthopedic Footwear Post-Pay Review Quarterly Status Report

Analysis of claim denials for orthopedic footwear HCPCS codes L3040, L3050, and L3060 reviewed between July 1, 2021 through September 30, 2021 revealed a denial rate of 100%. The top 7 reasons for claim denials are as follows:

| | | |
|---|---|---|
| 1 | The statutory coverage criteria have not been met for orthopedic footwear. | 81.88% |
| 2 | Medical records do not confirm the inserts and other shoe modifications are medically necessary for the proper functioning of the brace. | 7.19% |
| 3 | The documentation does not contain a valid detailed written order. Refer to Medicare Program Integrity Manual 5.2.3 PDF . | 4.38% |
| 4 | The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met. | 3.44% |
| 5 | The documentation does not contain a valid Standard Written Order (SWO). Refer to Standard Documentation Requirements A55426 EXT . | 2.19% |
| 6 | The supplier indicates the item(s) were billed in error. | 0.63% |
| 7 | The medical record documentation is illegible. | 0.31% |

**3**

## Surgical Dressings Post-Pay Review Quarterly Status Report

Analysis of claim denials for surgical dressings HCPCS codes A6196, A6212, and A6010 reviewed between July 1, 2021 and September 30, 2021 revealed a deni rate of 53.75%. The top 10 reasons for claim denials are as follows:

| | | |
|---|---|---|
| 1 | The monthly evaluation of the wound by the healthcare professional did not include the type of each wound, its location, its size and depth, the amount of drainage, and any other relevant information. | 16.80% |
| 2 | Medical records do not support that the surgical dressings are required for either the treatment of a wound caused by, or treated by, a surgical procedure; or when required after debridement of a wound. | 14.84% |
| 3 | Frequency of use or frequency of change is not supported by the medical records. | 10.16% |
| 4 | The medical records do not show that the Collagen dressing is being used on full thickness wound, a wound with light to moderate exudate or on a wound that has stalled or has not progressed towards a healing goal. | 9.53% |
| 5 | The medical records do not establish that the dressing is being used as a primary or secondary dressing or for some non-covered use (such as wound cleansing). | 9.06% |
| 6 | The medical records do not show that the Alginate or other fiber gelling dressing or filler is being used to cover or fill a moderately to highly exudative full thickness wound (stage III or stage IV ulcer). | 7.34% |
| 7 | The documentation does not contain a valid detailed written order. Refer to Medicare Program Integrity Manual 5.2.3 PDF . | 5.63% |
| 8 | The size of the wound in the medical records does not support the HCPCS code being billed. | 4.84% |
| 9 | The medical records do not show that the foam dressing is being used on a full thickness wound with moderate to heavy exudate (stage III or stage IV ulcer). | 4.61% |
| 10 | The medical records do not include an evaluation of the wounds performed on a monthly basis or justification for why they could not be evaluated monthly and what other methods were used to evaluate the need for the dressings. | 3.59% |

**4**

# Therapeutic Shoes/Inserts for Diabetic Persons Post-Pay Review Quarterly Statu Report

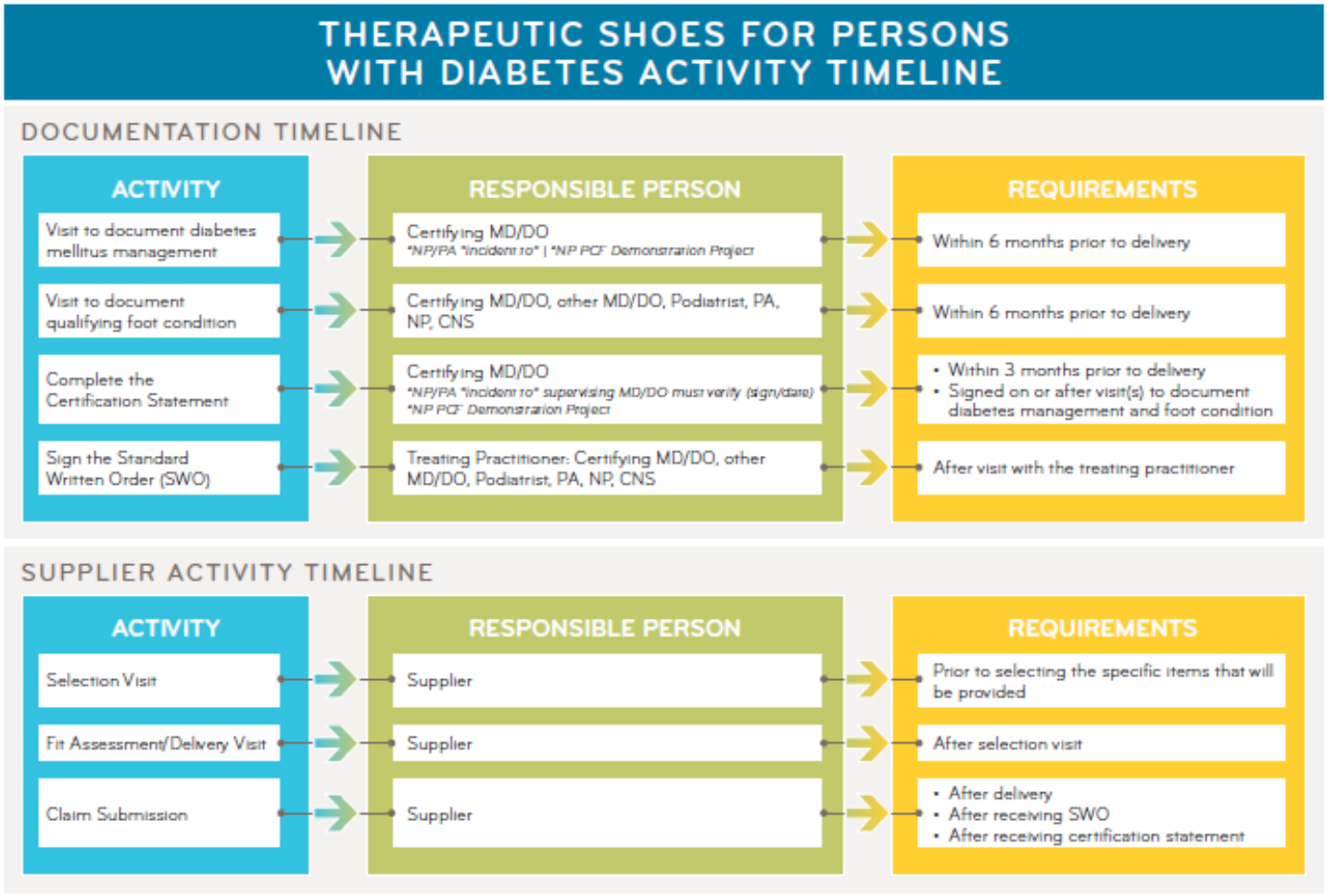
Analysis of claim denials for therapeutic shoes/inserts for diabetic persons HCPCS codes A5500 and A5512-A5514 reviewed between July 1, 2021 and Septembe 30, 2021 revealed a denial rate of 56.02%. The top 10 reasons for claim denials are as follows:

| | | |
|---|---|---|
| 1 | Medical record documentation does not include a clinical foot evaluation either conducted by the certifying physician or approved, initialed, and dated by the certifying physician. Therefore, there is no verification that the beneficiary had one of the six conditions. | 13.94% |
| 2 | The file does not include medical records from the certifying physician. | 13.33% |
| 3 | The patient's medical records do not indicate the presence of one or more of the six conditions the Local Coverage Determination (LCD) specifies must be present in order for the patient to meet coverage criteria for therapeutic shoes. | 7.27% |
| 4 | Documentation did not include an in-person supplier visit at the time of delivery that assessed the fit of the shoes and inserts with the patient wearing them. | 7.27% |
| 5 | Documentation did not include a Statement of Certifying Physician. | 6.97% |
| 6 | Documentation did not include an in-person evaluation of the patient's feet conducted by the supplier prior to selection of the specific items. | 5.15% |
| 7 | The medical records do not include a foot examination. | 4.85% |
| 8 | The medical records do not verify that the certifying physician is managing the patient's diabetes. | 3.94% |
| 9 | The documentation submitted does not include medical records from the prescribing practitioner. | 3.94% |
| 10 | The medical records confirm a diagnosis of peripheral neuropathy, but no evidence of callus formation is documented. | 3.03% |

**3)**

## Therapeutic Shoes for Persons with Diabetes

**I came across the following chart provided by CGS. It provides criteria in another format that may be of assistance.**




CGS
A CELERIAN GROUP COMPANY

Originated April 22, 2020 | Revised December 14, 2020


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

**4)**

**I have shared most, if not all, of the subject matter below. However, I felt it would be of benefit to provide some of the material presented by Paul Kesselman at the recent APMA CAC meeting. This should further reinforce and focus once again on Medicare/CMS initiatives and areas being targeted for review and/or audits. Additional information can also be accessed via the APMA website.**

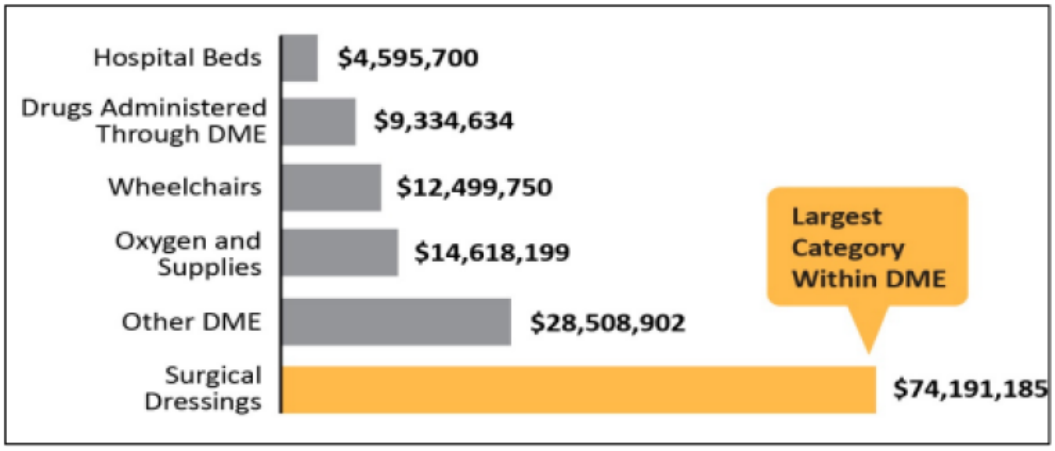
**a)**

At the time of the APMA CAC meeting, a DME fee schedule of approximately 5% increase was anticipated for 2022.

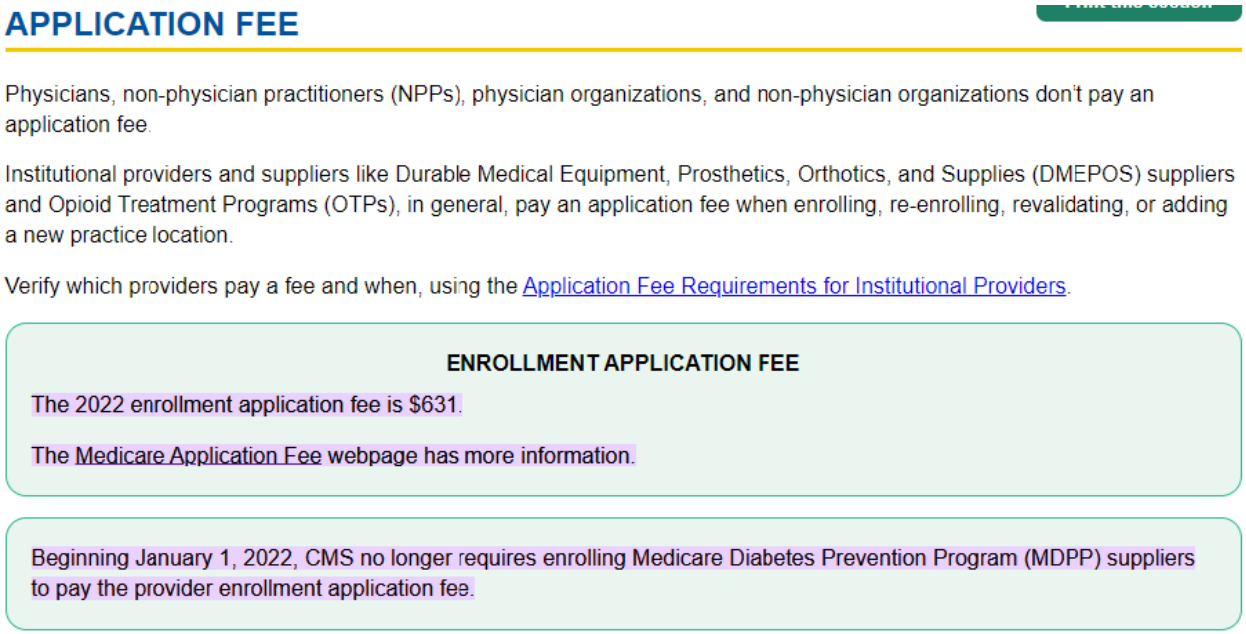
**b)**

Figure 2 shows the $143.7 million in Medicare Part B payments for DMEPOS items classified as DME according to the type of DME. The majority of DME items provided to hospice beneficiaries were for surgical dressings.

**Figure 2: Payments for Types of Durable Medical Equipment Provided to Hospice Beneficiaries During Our Audit Period**



**c)**



## APPLICATION FEE

Physicians, non-physician practitioners (NPPs), physician organizations, and non-physician organizations don't pay an application fee.

Institutional providers and suppliers like Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers and Opioid Treatment Programs (OTPs), in general, pay an application fee when enrolling, re-enrolling, revalidating, or adding a new practice location.

Verify which providers pay a fee and when, using the Application Fee Requirements for Institutional Providers.

**ENROLLMENT APPLICATION FEE**

The 2022 enrollment application fee is $631.

The Medicare Application Fee webpage has more information.

Beginning January 1, 2022, CMS no longer requires enrolling Medicare Diabetes Prevention Program (MDPP) suppliers to pay the provider enrollment application fee.

**d)**

# Physician Mistakes When Completing 855S

- List actual office hours to meet Hourly Requirement
- Lack of comprehensive list of DMEPOS (don't check orthotics)
- If PC or LLC Provide Individual NPI not Group NPI

**e)**

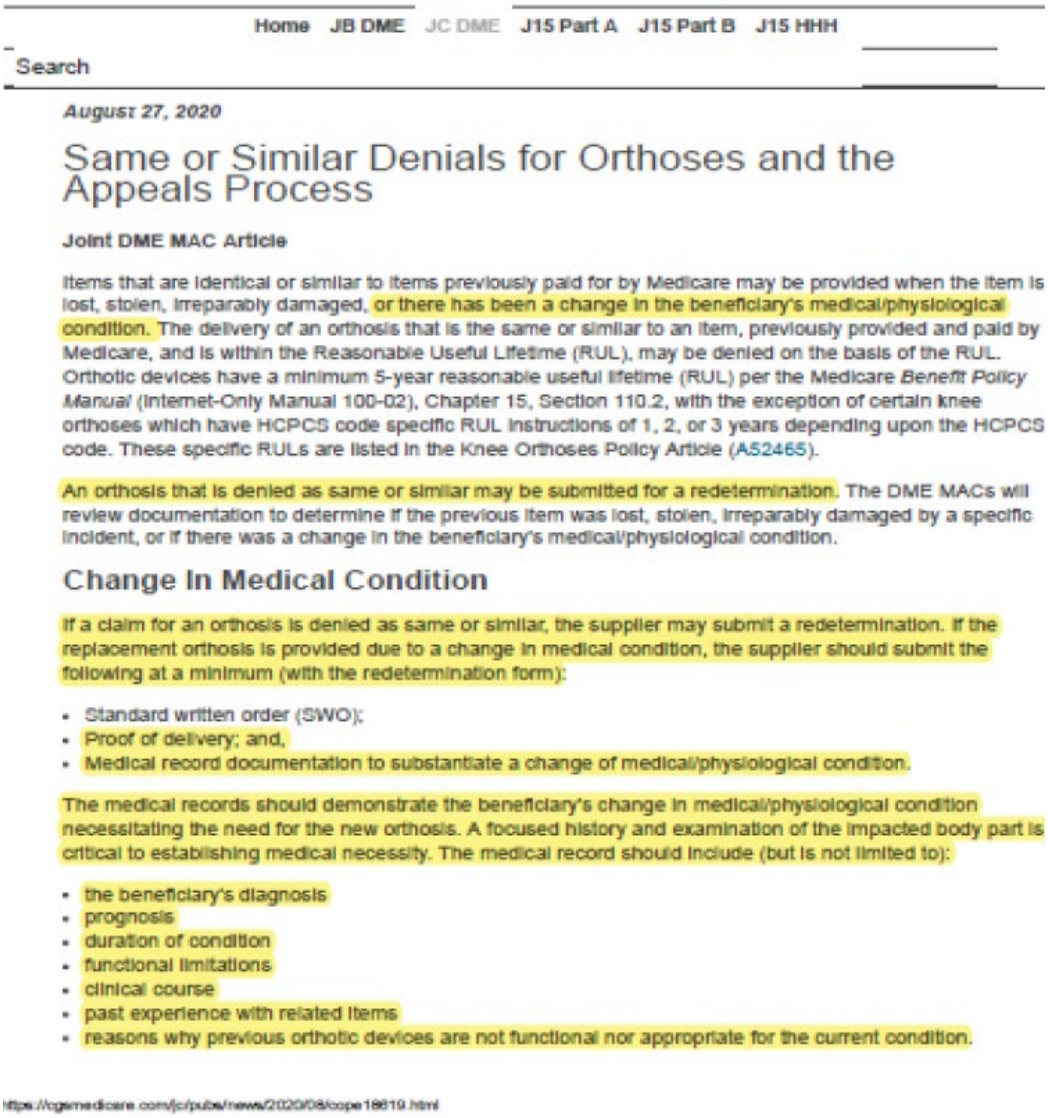
# Same and Similar (Not Much Updated Since 2020)

- Meeting with Other Stakeholders 12/04/20
- APTA, AOTA, AOPA, PFA, APMA
- Continued Correspondence With Joel Kaiser at CMS
- May Need to Transition Meetings with CMS Technology Dept
- Stuck on RUL 5 Year Rule (Except for Inceptions)
- AOTA &APTA Have Met With Joel Kaiser Within Last Few Weeks

**f)**

# Same or Similar Appeals

- Still Problematic if Not Using Portal
- Fax Frequent Interruption
- Frequent Denials—
- Lack of Proper Review By Auditors
- Despite Progression or Regression
- Change in Condition or Diagnosis
- RAC are most egregious in not following DME MAC Joint Publication



Home JB DME JC DME J15 Part A J15 Part B J15 HHH

Search

*August 27, 2020*

## Same or Similar Denials for Orthoses and the Appeals Process

**Joint DME MAC Article**

Items that are identical or similar to items previously paid for by Medicare may be provided when the item is lost, stolen, irreparably damaged, or there has been a change in the beneficiary's medical/physiological condition. The delivery of an orthosis that is the same or similar to an item, previously provided and paid by Medicare, and is within the Reasonable Useful Lifetime (RUL), may be denied on the basis of the RUL. Orthotic devices have a minimum 5-year reasonable useful lifetime (RUL) per the Medicare *Benefit Policy Manual* (Internet-Only Manual 100-02), Chapter 15, Section 110.2, with the exception of certain knee orthoses which have HCPCS code specific RUL instructions of 1, 2, or 3 years depending upon the HCPCS code. These specific RULs are listed in the Knee Orthoses Policy Article (A52465).

An orthosis that is denied as same or similar may be submitted for a redetermination. The DME MACs will review documentation to determine if the previous item was lost, stolen, irreparably damaged by a specific incident, or if there was a change in the beneficiary's medical/physiological condition.

### Change In Medical Condition

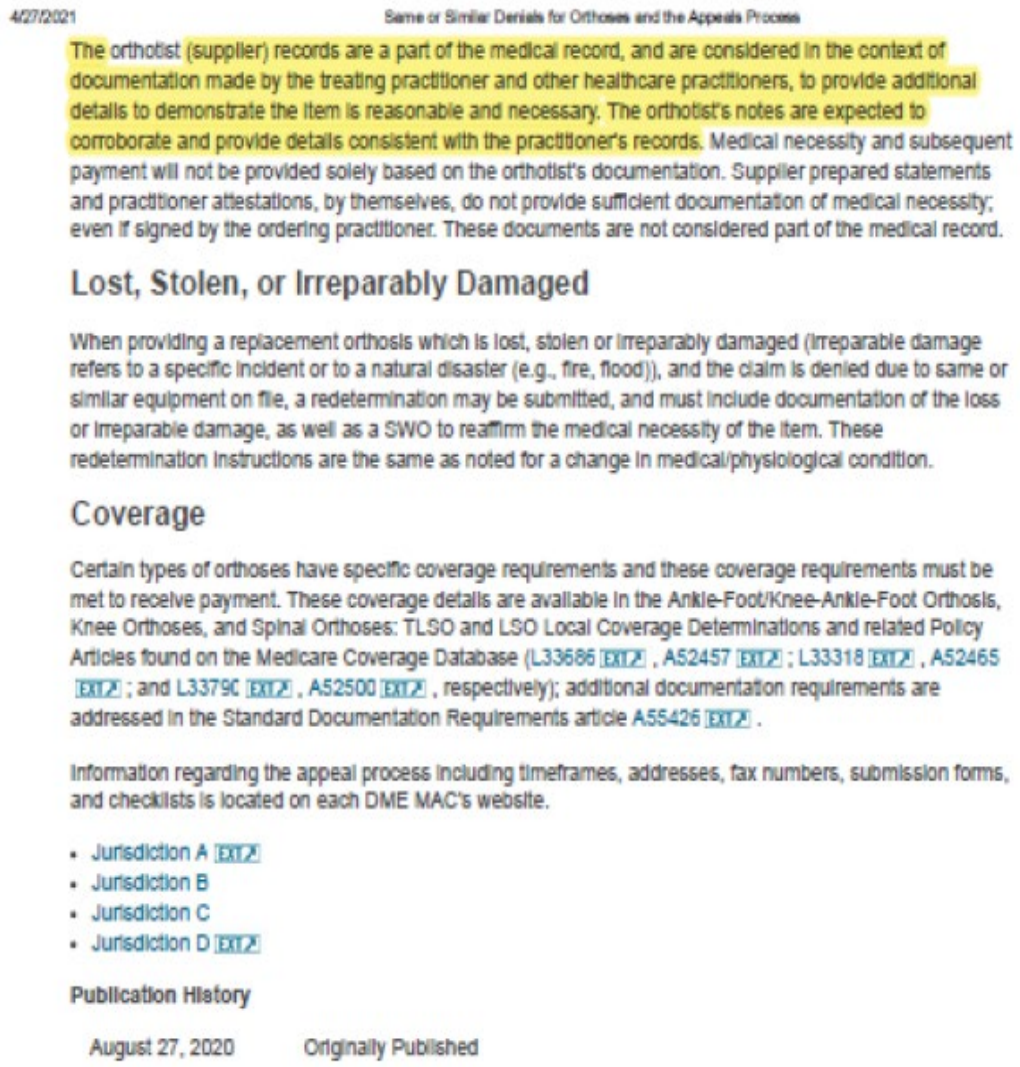
If a claim for an orthosis is denied as same or similar, the supplier may submit a redetermination. If the replacement orthosis is provided due to a change in medical condition, the supplier should submit the following at a minimum (with the redetermination form):

- Standard written order (SWO);
- Proof of delivery; and,
- Medical record documentation to substantiate a change of medical/physiological condition.

The medical records should demonstrate the beneficiary's change in medical/physiological condition necessitating the need for the new orthosis. A focused history and examination of the impacted body part is critical to establishing medical necessity. The medical record should include (but is not limited to):

- the beneficiary's diagnosis
- prognosis
- duration of condition
- functional limitations
- clinical course
- past experience with related items
- reasons why previous orthotic devices are not functional nor appropriate for the current condition.

https://cgsmedicare.com/jc/pubs/news/2020/08/cope18619.html



4/27/2021 Same or Similar Denials for Orthoses and the Appeals Process

The orthotist (supplier) records are a part of the medical record, and are considered in the context of documentation made by the treating practitioner and other healthcare practitioners, to provide additional details to demonstrate the item is reasonable and necessary. The orthotist's notes are expected to corroborate and provide details consistent with the practitioner's records. Medical necessity and subsequent payment will not be provided solely based on the orthotist's documentation. Supplier prepared statements and practitioner attestations, by themselves, do not provide sufficient documentation of medical necessity; even if signed by the ordering practitioner. These documents are not considered part of the medical record.

## Lost, Stolen, or Irreparably Damaged

When providing a replacement orthosis which is lost, stolen or irreparably damaged (irreparable damage refers to a specific incident or to a natural disaster (e.g., fire, flood)), and the claim is denied due to same or similar equipment on file, a redetermination may be submitted, and must include documentation of the loss or irreparable damage, as well as a SWO to reaffirm the medical necessity of the item. These redetermination instructions are the same as noted for a change in medical/physiological condition.

## Coverage

Certain types of orthoses have specific coverage requirements and these coverage requirements must be met to receive payment. These coverage details are available in the Ankle-Foot/Knee-Ankle-Foot Orthosis, Knee Orthoses, and Spinal Orthoses: TLSO and LSO Local Coverage Determinations and related Policy Articles found on the Medicare Coverage Database (L33686 EXT , A52457 EXT ; L33318 EXT , A52465 EXT ; and L3379C EXT , A52500 EXT , respectively); additional documentation requirements are addressed in the Standard Documentation Requirements article A55426 EXT .

Information regarding the appeal process including timeframes, addresses, fax numbers, submission forms, and checklists is located on each DME MAC's website.

- Jurisdiction A EXT
- Jurisdiction B
- Jurisdiction C
- Jurisdiction D EXT

**Publication History**

August 27, 2020 Originally Published

# Same or Similar Bottom Line

- Get the S/S Hx and SAVE IT to the patient's EMR
- Need to know what was previously dispensed if you did not
- Get the ICD10 (this will be provided in MyCGS 7.3)
- Document any Dx and Condition Changes from previous device
- Take Photos to illustrate how the device does not fit!
- Expect Denials
- Appeal Using Portal

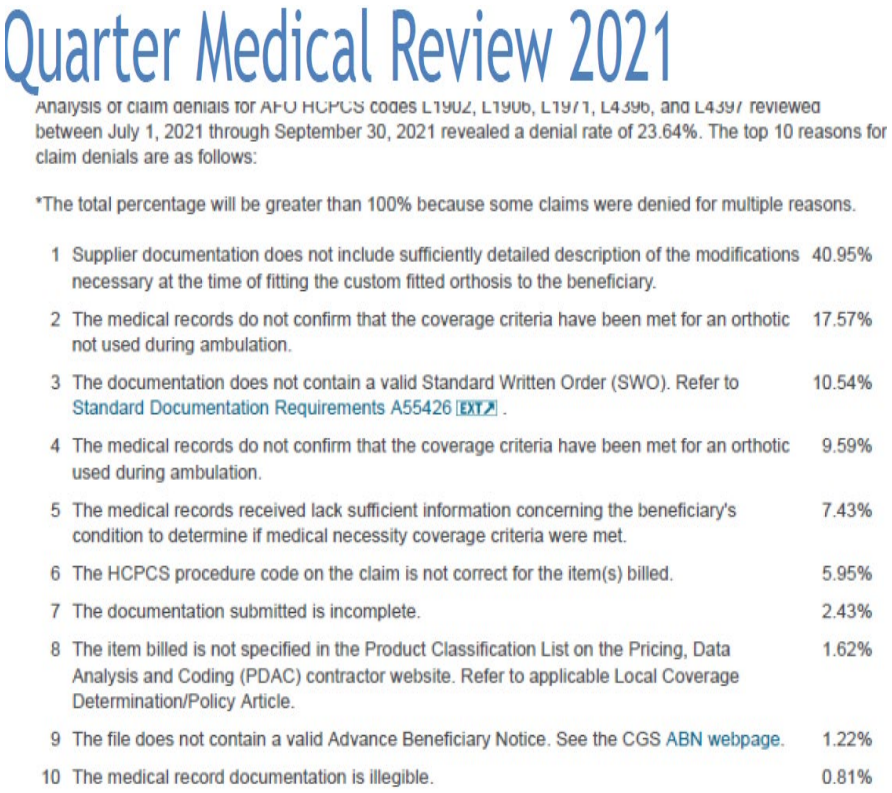
**g)**

# Surgical Dressing Audit Failures

- Lack of Appropriate Measurements (LxWxD)
- Drainage (Heavy, Moderate, Mild, None)
- Primary Dressing Incompatible With Drainage Requirements
- Statement of Dressing Capacity Being Met After X Days)
- Date of Last & Type of Debridement
- Incompatibility for Secondary or Need for Secondary Dressing
- Frequency and/or Units Incompatible With LCD
- Dressing Size Incompatible with Wound Size

**h)**

**Ankle-Foot Orthoses (AFO) Post-Pay Review Quarterly Status Report region JC.**



## Quarter Medical Review 2021

Analysis of claim denials for AFO HCPCS codes L1902, L1906, L1971, L4396, and L4397 reviewed between July 1, 2021 through September 30, 2021 revealed a denial rate of 23.64%. The top 10 reasons for claim denials are as follows:

*The total percentage will be greater than 100% because some claims were denied for multiple reasons.

| | | |
|---|---|---|
| 1 | Supplier documentation does not include sufficiently detailed description of the modifications necessary at the time of fitting the custom fitted orthosis to the beneficiary. | 40.95% |
| 2 | The medical records do not confirm that the coverage criteria have been met for an orthotic not used during ambulation. | 17.57% |
| 3 | The documentation does not contain a valid Standard Written Order (SWO). Refer to Standard Documentation Requirements A55426 EXT . | 10.54% |
| 4 | The medical records do not confirm that the coverage criteria have been met for an orthotic used during ambulation. | 9.59% |
| 5 | The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met. | 7.43% |
| 6 | The HCPCS procedure code on the claim is not correct for the item(s) billed. | 5.95% |
| 7 | The documentation submitted is incomplete. | 2.43% |
| 8 | The item billed is not specified in the Product Classification List on the Pricing, Data Analysis and Coding (PDAC) contractor website. Refer to applicable Local Coverage Determination/Policy Article. | 1.62% |
| 9 | The file does not contain a valid Advance Beneficiary Notice. See the CGS ABN webpage. | 1.22% |
| 10 | The medical record documentation is illegible. | 0.81% |

**i)**

**Therapeutic Shoes/Inserts for Diabetic Persons Post-Pay Review Quarterly Status Report region JC.**

# JC 3rd Quarter 2021

Analysis of claim denials for therapeutic shoes/inserts for diabetic persons HCPCS codes A5500 and A5512-A5514 reviewed between July 1, 2021 and September 30, 2021 revealed a denial rate of 56.02%. The top 10 reasons for claim denials are as follows:

| | | |
|---|---|---|
| 1 | Medical record documentation does not include a clinical foot evaluation either conducted by the certifying physician or approved, initialed, and dated by the certifying physician. Therefore, there is no verification that the beneficiary had one of the six conditions. | 13.94% |
| 2 | The file does not include medical records from the certifying physician. | 13.33% |
| 3 | The patient's medical records do not indicate the presence of one or more of the six conditions the Local Coverage Determination (LCD) specifies must be present in order for the patient to meet coverage criteria for therapeutic shoes. | 7.27% |
| 4 | Documentation did not include an in-person supplier visit at the time of delivery that assessed the fit of the shoes and inserts with the patient wearing them. | 7.27% |
| 5 | Documentation did not include a Statement of Certifying Physician. | 6.97% |
| 6 | Documentation did not include an in-person evaluation of the patient's feet conducted by the supplier prior to selection of the specific items. | 5.15% |
| 7 | The medical records do not include a foot examination. | 4.85% |
| 8 | The medical records do not verify that the certifying physician is managing the patient's diabetes. | 3.94% |
| 9 | The documentation submitted does not include medical records from the prescribing practitioner. | 3.94% |
| 10 | The medical records confirm a diagnosis of peripheral neuropathy, but no evidence of callus formation is documented. | 3.03% |

**j)**

**Orthopedic Footwear Post-Pay Review Quarterly Status Report region JC**

# 3rd QTR JC

## Orthopedic Footwear Post-Pay Review Quarterly Status Report

Analysis of claim denials for orthopedic footwear HCPCS codes L3040, L3050, and L3060 reviewed between July 1, 2021 through September 30, 2021 revealed a denial rate of 100%. The top 7 reasons for claim denials are as follows:

| | | |
|---|---|---|
| 1 | The statutory coverage criteria have not been met for orthopedic footwear. | 81.88% |
| 2 | Medical records do not confirm the inserts and other shoe modifications are medically necessary for the proper functioning of the brace. | 7.19% |
| 3 | The documentation does not contain a valid detailed written order. Refer to Medicare Program Integrity Manual 5.2.3 PDF . | 4.38% |
| 4 | The medical records received lack sufficient information concerning the beneficiary's condition to determine if medical necessity coverage criteria were met. | 3.44% |
| 5 | The documentation does not contain a valid Standard Written Order (SWO). Refer to Standard Documentation Requirements A55426 EXT . | 2.19% |
| 6 | The supplier indicates the item(s) were billed in error. | 0.63% |
| 7 | The medical record documentation is illegible. | 0.31% |

**k)**

## CERT ERROR RATES for DME (Excluding TS)

- DPM Order and Rx: Approx. 80%
- Lack of Response
- Lack of Providing Med Nec. (Conforming to LCD Req.)
- WPOD and NSC Issues

## Post Payment Audit Issues

- Lack of Medical Necessity
- Custom Fit Issues
- WPOD: Why DPM's Fail??
- MD/DO Issues with TSPD
- Fitting & Dispensing Notes

**l)**

## Surgical Dressing Audit Issues

- Debridement Date?
- Lack of Adequate Wound Measuring (LxWxD)
- Size Match
- Class of Dressing Inconsistent with Drainage (or exudate)
- Wrong # of Units

**m)**

## Therapeutic Shoe Update

- New Pathways for Certifying
- Current: NP/PA Working Incident to MD/DO May Certify
- Notes Must be Co Signed/Agreed to by Supervising MD/DO
- Effective November 5 2020
- Many Questions: Can PA/NP Attest to Agree to EP Findings
- EP: Not Cert MD/DO or DPM or other PA/NP??
- Does this set a precedent for supervisory role for NP/PA over DPM and/or Non-Supervisory MD/DO?

# III

# MEDICARE ADVANTAGE PLANS

**(Note: The first section of this report, Medicare, contains additional MA material that was presented during the annual APMA CAC meeting.)**

**1)**

**APMA recently published guidance regarding MA non-covered services. This information should answer many questions that have been come up regarding this subject.**

**One primary area of confusion is the misunderstanding that a Medicare ABN is to be used for MA plans as well as "original Medicare". The information below, as well as web links, should help clarify and provide guidance.**

**These resources, including a brief video and more, are available at www.apma.org/MedicareAdvantage.**

## *Billing for Non-Covered Services under Medicare Advantage Plans*

CMS has a long-standing position that Advance Beneficiary Notices and the authority behind them apply only under fee-for-service Medicare (also known as "original Medicare"). After a CMS audit of medical records for Medicare Advantage (MA) members uncovered ABNs in those files, CMS began reminding Medicare Advantage organizations (MAOs) of that position.

In 2014, CMS issued to MAOs a guidance letter that cited to Medicare Advantage law and guidance on this matter. In that letter, CMS stated its position that beneficiaries enrolled in MAOs may not be held liable for non-covered items or services unless they have received from the MAO a letter denying coverage for the item or service.

CMS' rationale for this position is that it views an MAO's contracted providers as its agents. Thus, when a contracted provider furnishes an item or service or makes a referral for a service to an MA member, the service or referral is viewed as authorized by the MAO. Therefore, the member may not be held liable for more than the applicable cost sharing when a contracted provider has furnished the service or made the referral. Consequently, CMS explained that the MAO itself must make it clear through a written notice when the MAO does not authorize such a service or referral.

In its 2014 guidance, CMS noted that, unlike under the fee-for-service Medicare program, MA members (or their providers acting on their behalf) always have a right to request a determination of whether a service will be covered by the plan (such a determination is known as an "organization determination"). MAOs must issue adverse organization determinations (or denials) in writing. CMS explained that a pre-service request for an organization determination that results in a written denial takes the place of the ABN used under fee-for-service Medicare. Once a member receives such a denial, if the member still wishes to obtain the non-covered item or service, they may be held financially liable for the cost.

CMS has subsequently refined its guidance to create a narrow exception from the general rule that a member may only be held liable for a non-covered service if they have received a written denial from the MAO.

In chapter 4, section 170 of the Medicare Managed Care Manual (CMS Pub#100-16) CMS explains that, in the case of certain services never covered by Medicare and identified in the MAO's evidence of coverage (EOC) as clearly never covered, the EOC is deemed to provide the notice of noncoverage and no written denial from the MAO is necessary in order to bill the MA member. But if the EOC indicates that the service is not typically covered, but could be covered under certain circumstances, it is still necessary to get a denial from the MAO in order to bill an MA member for a non-covered service.

The standard Medicare Advantage EOC that every MAO must use includes a table of exclusions from coverage. The table of services excluded from coverage includes three columns: one identifying the service that is not covered; one checked if the service is "not covered under any condition;" and one specifying when the service is "covered only under specific conditions."

Thus, only clearly identified services falling under the category "not covered under any condition" would fall under the exception from the obligation to obtain a written denial.

Routine foot care is listed under the "covered only under specific conditions" category with an explanation that there is "some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)." Thus, it would not fall under the exception.

"Supportive devices for the feet" are likewise included under the "covered only under specific conditions category" with the explanation that "orthopedic or therapeutic shoes for people with diabetic foot disease" are covered. Thus, they would also not fall under the exception.

Note that while "services considered not reasonable and necessary, according to the standards of Original Medicare" are listed as "not covered under any condition," they would not fall under the exception because it does not make clear whether a specific item or service is not covered, and beneficiaries are not considered to know when a service is reasonable or necessary.

Consequently, in order to bill an MA member for routine foot care or supportive devices for the feet (or any other service that does not fall under the exception), a physician should request an organization determination (or have the member request such a determination) from the relevant MAO prior to furnishing the service. Once the member receives a written denial saying the service is not covered, the physician can bill the member for the service. Such a notice would not be necessary each time the same service is provided if it is clear that the member should be on notice from the previous denial.

Physicians should also look at the MAO's provider manual to see if the MAO has any specific procedures or guidelines for holding an MA beneficiary liable for non-covered items and services.

**2)**

**Below is a recent publication from United Healthcare's recent notification regarding access to records for MA plans.**

# Medical records standards and requirements - Chapter 12, 2021 UnitedHealthcare Administrative Guide

## Access to records

Unless otherwise stated in your Agreement, you are required to:

- Send copies of our members' medical, financial, administrative, or purchasing and leasing records.
- Supply records within 14 calendar days, free of charge.
    - Supply records faster in certain circumstances.
- Maintain and protect records for 10 years.
- Give access to records for all dates of service that occurred when you were a contracted provider.
- Assist us, or our designee, in completing chart reviews for MA members.

# IV

# COMMERCIAL INSURANCE

## 1)

## a)

## No Surprises Act

**(<u>Note</u>: The first section of this report, Medicare, contains additional information on the "No Surprises Act" material that was presented during the annual APMA CAC meeting.)**

**I have included a communication on the "No Surprises Act" since it impacts all insurance products. This mandate deals with the billing of patients out of network, etc.**

**This is an emerging issue that has required additional clarification. To that end, there is an ongoing dialogue. However, I felt it would be helpful to include a communication I had regarding this emerging issue. In summary, it presently appears that there still exists some unanswered questions and guidance. APMA's member website also contains information on this subject.**

### 1/12/2022

Scott

Re: our conversation today.

I know you and Gail have a lot on your plates. To assist I felt I would provide a paper trail of my concerns regarding the No Surprises Act.

1) If I understand correctly a carrier can provide a market value for services. These designated payments would be applicable to providers not contracted with the carrier per rules of this Act.

   However I would argue there are pay parity issues arise. To better explain my concern I will present the following scenario:

   I have elected to not be a contracted provider with insurance company xyz.
   Patient Jones is seen in a facility that has a contract with insurance company xyz.
   Company xyz pays other specialties at 120% Medicare allowable and podiatry at 60%.

Based on this new Act, if I understand it correctly, I am now required to accept this reduced rate.

I find it aggreges that under legacy rules, I have the option of opting out especially due to the discriminatory practice of the carrier.

However this Act provides an avenue to force/require me to accept the discounted fee. Additionally this provides a distinct unfair advantage to the carrier.

I believe that this was not the intended spirit of this act. Hopefully we can bring this to the attention of any rule makers to provide fair and requisite adjustments.

2) Today I received an email from a list serve/attorney re: The No Surprise Act.

The following is an exert. I highlighted the major area of concern.
**I was under the impression that the highlighted text is misstated i.e. does not apply to a non contracted provider in an office environment.**

"On January 1, 2022, the No Surprises Act (the "Act"), went into effect. The purpose of the Act is to prohibit "surprise billing" by providers for emergency services and inadvertent out-of-network services at in-network facilities (inadvertent services). The Act applies to all health plans, including self-insured plans effective on or after January 1, 2022, with limited exceptions (i.e., qualified small employer health reimbursement arrangements). The Act **does not** apply to out-of-network providers at an out-of network facility, Florida law applies in this scenario.

Also starting on this same date, all healthcare providers **must** make publicly available information on patients' rights with respect to balance billing. Such notice should be posted to the provider's public website as well as posted in their offices. The notice **must** contain:

1. Information on the requirements established under the Act;
2. Information on any state-level protections, if applicable; and
3. Contact information for state and federal agencies to report any

potential violations.

Thanks for all your time and trouble assisting.

If I can further help or contribute I remain available as needed.

Mark

Mark S. Block, DPM

## b)

## The following is a response received re: above inquiry from APMA and consultants. It appears to clarify concerns that I raised in the above communication.

**Hi Mark –**

Apologies for not forwarding this last Friday. Let me know if you have any questions.

Best,

Gai

**From:** Robert S. Jasak <bjasak@hhs.com>
**Sent:** Wednesday, January 12, 2022 4:44 PM
**To:** Gail M. Reese, JD <greese@apma.org>; Cindy Moon <cmoon@hhs.com>
**Subject:** Re: No Surprises Act

Information in green. Let me know if you or your member have follow up questions.

Thanks!

Bob

Robert S. Jasak, J.D.
Vice President, Coverage and Payment Policy
**Hart Health Strategies Inc.**
202.729.9979 Ext. 109
bjasak@hhs.com
www.hhs.com

**From:** "Gail M. Reese, JD" <greese@apma.org>
**Date:** Wednesday, January 12, 2022 at 12:05 PM
**To:** Cindy Moon <cmoon@hhs.com>, "Robert S. Jasak" <bjasak@hhs.com>
**Subject:** FW: No Surprises Act

Hi Cindy –

Email below is as discussed at the start of todays call

**From:** Mark Block <msb@drmblock.com>
**Sent:** Wednesday, January 12, 2022 12:02 PM
**To:** Scott L. Haag, JD <shaag@apma.org>
**Cc:** Gail M. Reese, JD <greese@apma.org>
**Subject:** No Surprises Act

Scott

Re: our conversation today.

I know you and Gail have a lot on your plates. To assist I felt I would provide a paper trail of my concerns regarding the No Surprises Act.

3) If I understand correctly a carrier can provide a market value for services. These designated payments would be applicable to providers not contracted with the carrier per rules of this Act.
However I would argue there are pay parity issues arise. To better explain my concern I will present the following scenario:

I have elected to not be a contracted provider with insurance company xyz.
Patient Jones is seen in a facility that has a contract with insurance company xyz.
Company xyz pays other specialties at 120% Medicare allowable and podiatry at 60%.

Based on this new Act, if I understand it correctly, I am now required to accept this reduced rate.
I find it aggreges that under legacy rules, I have the option of opting out especially due to the discriminatory practice of the carrier.
However this Act provides an avenue to force/require me to accept the discounted fee. Additionally this provides a distinct unfair advantage to the carrier.

I believe that this was not the intended spirit of this act. Hopefully we can bring this to the attention of any rule makers to provide fair and requisite adjustments.

I think there is valid concern that this is where payments will drift, but for clarification, the law does not require you to accept any particular rate from a provider. For out-of-network non-emergency care (but only where there is a service furnished by an out-of-network provider **at an in-network facility** (as your scenario above contemplates), the law fundamentally does two things:

- Limits patient-cost sharing to what it roughly would have been if the care had been delivered in-network (let us know if you have questions about how this works) and prohibits providers from balance billing patients in these scenarios unless notice and consent provisions are met where the patient essentially waives the protections and agrees to be balanced billed by the out-of-network provider.
- In the event that the payer pays an amount with which you disagree, creates a federal independent dispute resolution process that can be accessed if there is no state law/regulation that speaks to those type of payment disputes.

Now- plans might start trying to pay you a reduced rate, and the cost of IDR might not be worth the difference in what the payer pays you and what you think you should be paid. But the law does *not* require you to accept a payment rate from an insurer any more or less than existed before (unless you follow through on federal IDR and the arbiter makes a payment determination, which is then binding). In addition, as mentioned above, if the patient is receiving care in a facility and you are out-of-network, you can go through the notice and consent process which would allow the patient to agree to your charges (they are consenting to being balance billed if all requirements are met).

Notice that we emphasized "at an in-network facility" above. I know your scenario involved a facility, but just a reminder that this set of protections and processes are *only* applicable when there is indeed some sort of facility involved. And facility is defined as "a hospital, a hospital outpatient department, a critical access hospital, or an ambulatory surgery center." Missing from that list you'll notice is the office setting. These provisions are not applicable to services you provide in the office setting, so in that way, the reach of the law is also limited.

4) Today I received an email from a list serve/attorney re: The No Surprise Act.
The following is an exert. I highlighted the major area of concern.
**I was under the impression that the highlighted text is misstated i.e. does not apply to a non contracted provider in an office environment.**

"On January 1, 2022, the No Surprises Act (the "Act"), went into effect. The purpose of the Act is to prohibit "surprise billing" by providers for emergency services and inadvertent out-of-network services at in-network facilities (inadvertent services). The Act applies to all health plans, including self-insured plans effective on or after January 1, 2022, with limited exceptions (i.e., qualified small employer health reimbursement arrangements). The Act **does not** apply to out-of-network providers at an out-of network facility, Florida law applies in this scenario.

Also starting on this same date, all healthcare providers **must** make publicly available information on patients' rights with respect to balance billing. Such notice should be posted to the provider's public website as well as posted in their offices. The notice **must** contain:

1. Information on the requirements established under the Act;
2. Information on any state-level protections, if applicable; and
3. Contact information for state and federal agencies to report any

potential violations.

The *No Surprises Act* does include requirements, that it refers to as a "disclosure." This is required *if* you are subject to the rules (we'll come back to that). If you are subject to the rules, the agencies have stated "The No Surprises Act requires providers/facilities subject to the rules to make publicly available, post on a website of the provider or facility (if applicable), and to provide to participants, beneficiaries, and enrollees a one-page notice about the balance billing requirements and prohibitions that apply to the provider or facility." The agency clarifies that there is also a requirement to post a sign in publicly accessible area of an office or facility.

However, the agencies have made clear that in order to avoid unnecessary confusion, regarding the disclosure itself (at least the one page disclosure):

- Providers are not required to make the disclosure "if they do not furnish items or services a health care facility, or in connection with visits at health care facilities" (See definition of facility above)
- Providers are required to make the disclosure only to individual to whom they furnish items and services (and only if those items and services are furnished at a health care facility or in connection with a visit at a health care facility)

Here is some of the precise language from the interim final rule:

> *Although section 2799B-3 of the PHS Act could be interpreted to apply broadly to all health care providers and facilities, these interim final rules include two exceptions to the general requirement to provide disclosures regarding balance billing protections. First, health care providers are not required to make the disclosures required under this section if they do not furnish items or services at a health care facility, or in connection with visits at health care facilities. Second, health care providers are required to provide the required disclosure only to individuals to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.*

It's a little easier to think about that from the perspective of delivery of the one-page document. For the website and public posting requirements, however, if there are *any* patients for whom you would provide services in connection with a "facility," website and publicly accessible areas of office postings would indeed be required. Here is a link to the model disclosure notice where you will also find additional information on the requirements and exceptions. In addition, here is the interim final rule language on posting in a public area:

> *To satisfy the required disclosure to the public, providers and facilities must display the required disclosure information on a sign posted prominently at the location of the health care provider or health care facility. HHS would consider a sign to be posted prominently, if the sign were posted in a central location, such as where individuals schedule care, check-in for appointments, or pay bills. Such locations would allow individuals to be aware of the protections available before or at the time of service or payment. HHS is of the view that ensuring the individual is aware of the surprise billing protections is integral to implementation of these requirements. HHS recognizes that some providers may not have publicly accessible locations and has concluded that requiring a sign to be posted prominently at a non-publicly accessible location would not further the purpose of providing a disclosure. Therefore, providers without a publicly accessible location are not required to make the disclosure under 45 CFR 149.430(c)(2).*

However, to the extent that you are furnishing services at a "facility," providers can sign an agreement with a "facility," that the facility will provide the one-page disclosure and make the public posting. While, the interim final rule states that this provider flexibility does not extend to the requirement that the disclosure be included on the website, this is an option that can be explored with any facility where you furnish services. The actual regulation language is as follows:

> *(f) **Special rule to prevent unnecessary duplication with respect to health care providers**. To the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (including an emergency department of a hospital or independent freestanding emergency department), the provider satisfies the requirements of paragraphs (c)(2) and (3) of this section if the facility makes the information available, in the required form and manner, pursuant to a written agreement. Accordingly, if a provider and facility enter into a written agreement under which the facility agrees to make the information required under this section available on a sign posted prominently at the facility and to provide the one-page notice to individuals in compliance with this section, and the facility fails to do so, then the facility, but not the provider, violates the disclosure requirements of this section.*

Thanks for all your time and trouble assisting.

If I can further help or contribute I remain available as needed.

Mark

Mark S. Block, DPM

# V

# Miscellaneous Relevant Information and Communications

## 1)

## MIPS Related Updates

The Centers for Medicare & Medicaid Services (CMS) continues to provide relief where possible to clinicians responding to the 2019 Coronavirus (COVID-19) public health emergency (PHE). We're applying the Merit-based Incentive Payment System (MIPS) automatic extreme and uncontrollable circumstances (EUC) policy to ALL individually eligible MIPS eligible clinicians for the 2021 performance year (PY). Please note that this announcement is for PY2021 only.
The automatic EUC policy only applies to MIPS eligible clinicians who are eligible to participate in MIPS as individuals. The automatic EUC policy doesn't apply to groups, virtual groups, or Alternative Payment Model (APM) Entities.

Learn what this means for you below.
MIPS eligible clinicians who are eligible to participate in MIPS as individuals
You don't need to take any action to have the automatic EUC policy applied to you. You'll be automatically identified and will have all 4 MIPS performance categories reweighted to 0% and receive a neutral payment adjustment for the 2023 MIPS payment year unless you

1) submit data in 2 or more performance categories, or

2) have a higher final score from group or APM Entity participation.

Small practices reporting Medicare Part B claims measures
Under current policies, we automatically calculate a quality score from Medicare Part B claims measures at the individual and group level.

• Clinicians in small practices that report Medicare Part B claims measures who are only eligible to participate in MIPS as part of a group aren't covered by the automatic EUC policy and will receive the group's final score. (To identify these clinicians, sign in to qpp.cms.gov, navigate to the "Eligibility & Reporting" page and click "View Clinician Eligibility". Clinicians who are only

eligible to participate as part of a group will have a green check mark next to "Group"; there won't be a green check mark next to "Individual".)

• Some small practices may not be aware of the implications of their PY 2021 claims reporting due to some of the policies we introduced at the onset of the COVID-19 PHE.

• As a result, these small practices may wish to request performance category reweighting on behalf of the group through the PY2021 EUC Exception Application, citing COVID-19 as the triggering event.

• PY2021 EUC Exception Applications can be submitted by signing in to qpp.cms.gov and clicking Exception Applications on the left-hand navigation.

Groups
The automatic EUC policy doesn't apply to groups. You don't need to take any further action if you're not able to submit data for the 2021 performance year. Group participation is optional (specific guidance for small practices noted above), and your individually eligible MIPS eligible clinicians qualify for the automatic EUC policy if you don't report at the group-level on their behalf. (If you submit data at the group level on behalf of your MIPS eligible clinicians, the group will receive a MIPS final score based on the data submitted.) Your MIPS eligible clinicians will have all 4 performance categories reweighted to 0% and receive a neutral payment adjustment for the 2023 MIPS payment year unless

1) they submit data in 2 or more performance categories, or

2) they have a higher final score from group or APM Entity participation.

For further questions related to the Quality Payment Program or if further assistance is needed, please contact our Quality Service Center

# VI

# Q&A (Misc. Member Issues)

## As noted in the opening statement of this report, many items are archived with relevant issues incorporated into other sections of this report. However, I am providing several other communications as an FYI.

## 1)

## The attachments noted in the email inquiry below are not being published. I felt the guidance I provided is relevant to a generic understanding of billing and claims adjudication.

Dr xxxx

Karen Lamber had asked that I attempt to provide guidance and assistance.

After reading and evaluating the above PDF I researched the edits etc.

I am providing the above word document that I composed to assist your understanding of the possible cause of your issue.

The word document contains CCI edit pairs for two of your codes.

It appears that that the splint (28515) may have resulted in the denial.

However I would disagree with their denying the other procedure codes based on the documentation you supplied.

Be aware that some carriers will bypass an edit and sometimes pay inappropriately if a claim is submitted with a modifier that is unintended for the code pair (this may be the reason for past payments from other carriers).

Therefore if you were paid in the past it may have been in error and should not necessarily be re construed as validation that the claim was paid appropriately.

(This could result in a post payment review and request for refund.)

In summary in my opinion you have several options.

1) Amend the claim and rebill the surgical codes without submission of 29515 (splint). Ironically, if even paid, allowance would likely be at 50% of an already discounted allowance. The amount that would be paid for the splint likely would not come close to compensating for the time and trouble of staff etc. to obtain restitution.
2) If necessary reach out to the local UHC rep., claims person or Medical Director stating the issue and non payment.

I you have any further questions I remain available and will try to assist.

Fraternally,
Mark

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association
Past President Florida Podiatric Medical Association
Chair Emeritus, Health Policy and Practice Committee, American Podiatric Medical Association
Past CPA Advisory Group-State Component Leader APMA
Chair Emeritus, APMA Coding Committee
Vice Chair Florida Board of Podiatric Medicine
Diplomate, American Board of Foot and Ankle Surgery, Certified in Foot Surgery
AAPC Certified Surgical Foot & Ankle Coder (CSFAC)
Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com



**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Friday, October 8, 2021 7:26 AM
**To:** Mark Block <msb@drmblock.com>
**Subject:** FPMA: UHC denial (assistance request from FPMA member)

Dr. Block,

Will you please take a look and let me know what you advise?

Or better, would you please reply to Dr. Daly directly and copy me?

I am on the road today down to Shands.

Thank you,

Karen Lambert

---------- Original Message ----------

From: xxxx xxxx
To: "'klambert@fpma.com'" <klambert@fpma.com>
Date: October 7, 2021 2:45 PM
Subject: UHC denial

Dear Ms. Lambert,

I called yesterday and spoke with someone in customer service in reference to a claim denial associated with a UHC/AARP Medicare replacement policy. I was instructed to email you with the details. The claims is for a surgery performed on February 18, 2021, to date this claim remains unpaid.

Please find attached an outlined letter with all documentation.  Thank you for your assistance.

Sincerely,

xxxxx DPM

xxx-xxx-xxxx

## 2)

xxxxxx

I just went to the FCSO fee lookup for 11721 and found the following.

So it appears to be working.

| | | | |
|---|---|---|---|
| **Fee Schedule** | MPFS | **Procedure Code** | 11721 |
| **State** | FL | **Locality** | 03 |
| **Record Effective Date** | 01/01/2021 | **Description** | Debride nail 6 or more |

| **NON OPPS** | |
|---|---|
| NON FAC PAR | 46.59 |
| NON FAC NON PAR | 44.26 |
| NON FAC LC | 50.90 |
| NON FAC eRx LC | N/A |

Mark

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association
Past President Florida Podiatric Medical Association
Chair Emeritus, Health Policy and Practice Committee, American Podiatric Medical Association
Past CPA Advisory Group-State Component Leader APMA
Chair Emeritus, APMA Coding Committee
Vice Chair Florida Board of Podiatric Medicine
Diplomate, American Board of Foot and Ankle Surgery, Certified in Foot Surgery
AAPC Certified Surgical Foot & Ankle Coder  (CSFAC)
Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com

**From:** xxxxx <xxx.com>
**Sent:** Sunday, December 19, 2021 7:00 PM
**To:** Mark Block <msb@drmblock.com>
**Subject:** Fwd: 2022 fee schedule revision CMS Medicare question for podiatry codes

Sorry to bother you Mark, my error. All good.

XXXXXX

---------- Forwarded message ---------
From: **xxxxxx** <xxxxgmail.com>
Date: Sun, Dec 19, 2021 at 3:37 PM
Subject: 2022 fee schedule revision CMS Medicare question for podiatry codes
To: <msb@drmblock.com>

Hello Mark,

This afternoon I was looking at a revised 12-17-21 listing of approved physician fees for FL CMS Medicare procedure codes for 2022, location 3.

Codes 11055,11056, 11057, and 11720, 11721 were not listed.

I just looked 2 hours later, and there was no revision listing on 12-17-21 to be found on the medicare.fcso.com website. Very odd.

Do you know anything about this?

xxxxx, DPM

## 3)

## Amniotic Injections Issue

FYI

Feel free to share this with others on the call if inclined.

Update:

Spoke to the practice re: amniotic injections.

They did in fact use to inject tendons.

Advised them that this was not an approved procedure for MC and that commercial carriers should provide preauthorization before utilizing the product.

Also advised them that APMA has in the past posted information regarding utilization/recommendations.

Mark

**From:** Scott L. Haag, JD <shaag@apma.org>
**Sent:** Friday, February 18, 2022 10:33 AM
**To:** Mark Block <msb@drmblock.com>
**Cc:** Chad L. Appel, JD <cappel@apma.org>; Gail M. Reese, JD <greese@apma.org>
**Subject:** RE: Amniotic injection issue

Mark:

I did not receive the letter attachments. Can you resend please?

Thanks

**NOTE: Find the APMA COVID-19 recommendations at www.apma.org/covid19.**

Note that my work email address has changed to shaag@apma.org effective immediately. Please update your records appropriately. I will continue to receive emails addressed to slhaag@apma.org for the indefinite future.

**Scott L. Haag, JD, MSPH**
**Director, Health Policy & Practice**
**Advisor, Center for Professional Advocacy**
**American Podiatric Medical Association, Inc.**
**9312 Old Georgetown Road**
**Bethesda, MD 20814**
**Office: (301) 581-9200**
**Fax: (301) 571-4905**
**shaag@apma.org**

 | 

**From:** Mark Block <msb@drmblock.com>
**Sent:** Friday, February 18, 2022 9:16 AM
**To:** Scott L. Haag, JD <shaag@apma.org>
**Cc:** Chad L. Appel, JD <cappel@apma.org>; Gail M. Reese, JD <greese@apma.org>
**Subject:** Amniotic injection issue

Scott

A member sent me the above letters that was received by their patients.

I personally though it was only a matter of time before this blew up.

If we have a call today I would like to put this on the agenda for discussion.

In the interim I will be reaching out to the provider to discuss.

Thanks

Mark

Mark S. Block, DPM

**4)**

**Nurse Practitioner question. This subject has come up numerous times. The explanation below should shed a better understanding of the issue/guidelines.**

I researched and came across the following :

"Qualified nurse practitioners will be able to independently operate primary care practices without an attending doctor's supervision under a bill (**HB 607**) passed by the Legislature and signed hours later by Gov. **Ron DeSantis**."

The below LCD/article that I sent yesterday states:

In states where the NP may practice independently, the NP's employment situation would require compliance with Medicare "incident to" rules in order to serve as the certifying physician. Please refer to the applicable A/B MAC for further information.

Hopefully this addresses the issue in question and is of assistance.

As a side note, this patient scenario appears to be an anomaly.

In a vast majority of cases, Medicare patients have an MD or DO as a primary provider.

Is this a unique insurance and doesn't the patient have an endocrinologist managing the diabetes?

Mark

Mark S. Block, DPM, FASPS, CWS, CSFAC

Chair Insurance Committee, Florida Podiatric Medical Association
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Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com

**From:** Dr. xxx <xxxxx@msn.com>
**Sent:** Wednesday, October 20, 2021 5:31 AM
**To:** Mark Block <msb@drmblock.com>
**Cc:** klambert@fpma.com
**Subject:** Re: FPMA: Can a Nurse Practitioner Physician sign for diabetic shoes care of Medicare?

Good morning Mark,

Thank you for the quick response. I am aware of the published information but the reason I asked was that the Nurse Practioner is the Chief Medical Officier at this practice and he does not have a MD or DO that supervises him. He is a sole practicioner. I know there are circumstances in rural areas where the NP/PA do not have a supervising physician overseeing them.

I did reach out to the Association because it seems the scope of practice for NP/Doctor of Nurse Practioner has changed and if they are allowed to sign Certifying Physician Statement. From how the guidelines read, the answer is still no.

This is very confusing for us and you can imagine that the patient is even more confused. They know him as their Dr.

Thank you,

Dr. xxx

---

**From:** Mark Block <msb@drmblock.com>
**Sent:** Tuesday, October 19, 2021 3:59 PM
**To:** xxx@msn.com <xxxx@msn.com>
**Cc:** klambert@fpma.com <klambert@fpma.com>
**Subject:** RE: FPMA: Can a Nurse Practitioner Physician sign for diabetic shoes care of Medicare?

The policy and associated Article are published and available to all interested parties.

For future reference, you should consider accessing this published information.

However I have taken the liberty of accessing the policy.

I highlighted the verbiage that I trust provides the guidance you require.

Fraternally,

Mark

Mark Block DPM

# Contractor Information

# Article Information

## General Information

**Article ID**
A52501

**Original ICD-9 Article ID**
A47129
A37065
A37218
A37076

**Article Title**
Therapeutic Shoes for Persons with Diabetes - Policy Article

**Article Type**
Article

**Original Effective Date**
10/01/2015

**Revision Effective Date**
11/05/2020

**Revision Ending Date**
N/A

**Retirement Date**
N/A

**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**

## Article Guidance

### Article Text

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Therapeutic Shoes and inserts are covered under the Therapeutic Shoes for Individuals with Diabetes benefit (Social Security Act §1861(s)(12)). In order for a beneficiary’s equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

For an item addressed in this policy to be covered by Medicare, a Standard Written Order (SWO) must be communicated to the supplier prior to claim submission. If the supplier bills for an item without first receiving the SWO, the item will be denied as statutorily noncovered.

The Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the beneficiary’s diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist or clinical nurse specialist. Consequent to the M.D. or D.O. restriction, a nurse practitioner (NP) and a physician assistant (PA) may not serve in the role of the certifying physician, unless practicing “incident to” the supervising physician’s authority, as described below.

NPs or PAs providing ancillary services as auxiliary personnel could meet the “incident to” requirements in their provision of therapeutic shoes to beneficiaries with diabetes if all of the following criteria are met:

1. The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; and,
2. The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient; and,
3. The supervising physician must review and verify (sign and date) all of the NP or PA notes in the medical record pertaining to the provision of the therapeutic shoes, acknowledging their agreement with the actions of the NP or PA.

In states where the NP may practice independently, the NP's employment situation would require compliance with Medicare "incident to" rules in order to serve as the certifying physician. Please refer to the applicable A/B MAC for further information.

The Prescribing Practitioner is the person who actually writes the order for the therapeutic shoe, modifications and inserts. This practitioner must be knowledgeable in the fitting of diabetic shoes and inserts. The prescribing practitioner may be a podiatrist, M.D., D.O., physician assistant, nurse practitioner, or clinical nurse specialist. The prescribing practitioner may be the supplier (i.e., the one who furnishes the footwear).

The Supplier is the person or entity that actually furnishes the shoe, modification, and/or insert to the beneficiary and that bills Medicare. The supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Practitioner may be the supplier. The Certifying Physician may only be the supplier if the certifying physician is practicing in a defined rural area or a defined health professional shortage area.

**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Tuesday, October 19, 2021 9:52 AM
**To:** Mark Block <msb@drmblock.com>
**Subject:** FPMA: Can a Nurse Practitioner Physician sign for diabetic shoes care of Medicare?

Dr. Block,

Dr. xxx has a question regarding diabetic shoes. Please see below.

Thank you in advance for your reply. Feel free to respond to her via email and copy me if you will.

Best Regards,
Karen Lambert

---------- Original Message ----------
From: "Dr. xxxx" <xxxxx>
To: "admin@fpma.com" <admin@fpma.com>
Date: October 19, 2021 9:17 AM
Subject: Can you help?

Good morning,

I have a patient who is being seen by Prestige Clinicians LLC whose Chief medical officier is Mr. Henry Odazie, DNP. His NPI is 1740880848 and is defined as a Nurse Practicioner Physician.

We have called to see if there is a MD or DO that oversees but he is the CMO.

Is he able to sign for Diabetic shoes for Medicare?

Thank you,

Dr. xxx

## 5)

## At Risk Foot Care Payment Issues

Coincidently, I was on a call with APMA last week and this issue came up. As a result, APMA is investigating this issue and hopefully there will more to report as we further investigate. In the interim I listed several thoughts that might be helpful.

1) This could be an issue with the carrier' s claims processing software etc.
2) Appropriate modifiers are necessary if applicable.
3) If they defer to the Medicare policy, read/review the LCD and Article if necessary for guidance. There may be an issue with the submissions not meeting appropriate format etc.
1) If in fact they utilize the Medicare LCD/Article for adjudication of claims and they are not in compliance inform them of this fact.
2) I would also suggest that you consider the appeals process with WellCare. They should have guidance regarding the protocol for registering an appeal.
   a) Please keep me in the loop so that I can communicate with APMA. Any information obtained will be helpful if we/the Association are to challenge any inappropriate provider denials.
   b) **There has been some suspicion that this is an issue for Medicaid products. If this has been your experience please let me know.**

Hope this information is helpful.

Fraternally,
Mark

Mark S. Block, DPM
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association

**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Monday, October 25, 2021 10:27 AM
**To:** Mark Block <msb@drmblock.com>
**Subject:** FPMA: Member (Dr. xxxx) Welcare denials for at risk foot care

Dr. Block,

Please see email from xxxxx, a FPMA member in good standing, below.

To the best of your knowledge are others experiencing these denials also?

What do you advise xxxxxxx?

Thank you,

Karen Lambert

---------- Original Message ----------

From: xxxxxx <xxxxxxx.com>

To: klambert@fpma.com

Date: October 25, 2021 9:26 AM

Subject: Welcare denials for at risk foot care

Ms Lambert,

My billing company since the beginning of 2021 has been having a very difficult time getting at risk foot care covered for our patients when we bill a debridement of callus code (1105X) with a nail debridement code (11719, 11720, 11721). They state that it goes against the NCCI edits which we know is not true.

Have you heard of other podiatrists with this same issue? If not, is there someone we can contact to make this right. They are the only payer that I am having this issue with and do not believe it is right.

Thank you for your time.

**xxxxxx DPM, FACPM**

-Board Certified, American Board of Podiatric Medicine--CAQ in Amputation Prevention and Wound Care
-Certified Wound Care Specialist Physician--American Board of Wound Management

**xxxxxxxxxxxxxxx**

**Office:** XXX.XXX.XXXX
**Fax:** xxxxxxxxxx
**Mobile:** xxxxxxx
www.xxxxxxxpodiatry.com

## 6)

## DME Supplier Question

CR 12282 States the following:

B. Policy: In those seventeen states that have indicated that provision of prosthetics and orthotics must be made by licensed/certified orthotist or prosthetist, Medicare payment may only be made for prosthetics and certain custom-fabricated orthotics when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel and prosthetics personnel. These specialties shall bill for Medicare services when State law permits such entity to furnish an item of prosthetic or orthotic.

I trust this answers the question.

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association
Past President Florida Podiatric Medical Association
Chair Emeritus, Health Policy and Practice Committee, American Podiatric Medical Association
Past CPA Advisory Group-State Component Leader APMA
Chair Emeritus, APMA Coding Committee
Vice Chair Florida Board of Podiatric Medicine
Diplomate, American Board of Foot and Ankle Surgery, Certified in Foot Surgery
AAPC Certified Surgical Foot & Ankle Coder (CSFAC)
Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com



**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Monday, September 20, 2021 2:21 PM
**To:** Mark Block <msb@drmblock.com>
**Subject:** FPMA: Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics

Dr. Block,

Submitted for your review and response to Dr. xxxxxxxx.

Thank you,

Karen Lambert

---------- Original Message ----------

From: egroves <egroves@fpma.com>

To: "klambert fpma.com" <klambert@fpma.com>

Date: September 20, 2021 2:12 PM

Subject: Fwd: Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics

---------- Original Message ----------

From: vvvv Podiatry <vvvvv@hotmail.com>

To: "egroves@fpma.com" <egroves@fpma.com>

Cc: vvvvv <vvvvv.com>

Date: September 20, 2021 12:47 PM

Subject: Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics

Hi Erin!

Thank you for your time and any assistance you are able to provide.

I came across this CMS rule (first link below) which appears will apply to dates of service on or after 10/01/21. Can you please review this when you have time to see if I am correctly understanding? It looks to me like we cannot bill these codes unless we change our specialty code with NSC? Maybe I am misinterpreting what they are trying to say? I had one of our providers review the information as well and he understood it the same way I did.

From what I am understanding, the rule is stating certain HCPCS codes will now require the use of a licensed / certified orthotist or prosthetist for furnishing custom fabricated and prefabricated orthoses. It further states, if you wish to furnish the items and you are not a certified orthotist or prosthetist the claim will be denied.

**The main question we are trying to understand is, it appears in order for us to supply these codes we must be a licensed / certified orthotist or prosthetist? So, just being a podiatrist would not be sufficient?**

Of course, they do not provide a list of the HCPCS codes they are referencing. I was able to find where they said it would be for categories of OR01, OR02 and OR03. I have listed the descriptions of these category codes for you below. I looked up these category codes and was able to find a list of HCPCS codes; the list is in the second Link below (Noridian article).

I will keep digging for a better list of HCPCS codes this would apply to but for now the two codes which may apply to us are **L1910 and L1971.**

- OR01 - ORTHOSES: CUSTOM FABRICATED
  - CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
- OR02 - ORTHOSES: PREFABRICATED (CUSTOM FITTED)
  - PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
  - **PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT** (emphasis added)
- OR03 - ORTHOSES: OFF-THE-SHELF
  - PREFABRICATED, OFF-THE-SHELF

CMS issued CR 12282 EXT to communicate the addition of HCPCS codes that require the use of a licensed/certified orthotist or prosthetist for furnishing custom fabricated and prefabricated (custom fitted) orthoses. **This change will apply to dates of service on or after October 1, 2021.**

Claims for Items furnished by personnel who are not licensed/certified orthotists or prosthetists by the state in which they practice will be denied. The following states require a licensed/certified orthotist or prosthetist to furnish orthotics or prosthetics: Alabama, Arkansas, Connecticut, Florida, Georgia, Idaho, Illinois, Iowa, Kentucky, Maryland, Minnesota, Mississippi, Nevada, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, and Washington.

**Effective for dates of service on or after October 1, 2021, if a supplier is located in one of the applicable states and wishes to bill Medicare for the prosthetics and custom fabricated orthotics attached to this CR EXT , it must properly enroll with the National Supplier Clearinghouse (NSC) EXT to ensure the correct specialty code(s) is on file.**

If a supplier should need to update its file with the correct specialty, the supplier must submit a "Change of Information" on Form CMS-855S to the NSC EXT along with all applicable licenses or certifications.

https://www.cgsmedicare.com/jb/pubs/news/2021/05/cope22145.html

CGS
A CELERIAN GROUP COMPANY

## Additional Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics - Updated - CGS Medicare

May 25, 2021 - Updated July 22, 2021. Additional Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics - Updated. Effective Date: October 1, 2021

www.cgsmedicare.com

https://med.noridianmedicare.com/web/jadme/policies/dmd-articles/2021/custom-fitted-orthotic-hcpcs-codes-without-a-corresponding-off-the-shelf-code-correct-coding

noridian
Healthcare Solutions
JA

## Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding - JA DME - Noridian

To identify Prefabricated Custom Fitted codes which have a corresponding Prefabricated Off -the-Shelf HCPCS code, suppliers should reference the joint DME MAC article "Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correct Coding - Revised. If you have questions, please contact the PDAC HCPCS Helpline at (877) 735-1326 during the hours of 9:30 a.m ...

med.noridianmedicare.com

**xxxxxxxxxx**
**xxxxxxxxx Podiatry**
xxxxxxxxxx
T xxxxxxxxxx
Mxxxxxxxxxxxxxx
vvvvvvvv.com



**Sincerely,**

**Erin Groves**
*Senior Executive Officer*
**Florida Podiatric Medical Association**
410 North Gadsden Street, Tallahassee, Florida 32301
(850) 224-4085 direct **|** 1-800-277-3338 toll free

## 7)

## DME Coverage Question re: Gauntlets

Medicare does not cover these devices for the purpose that you indicated.

Historically as I recall the utilization that you have elected was promoted a number of years ago. It has since been frowned upon by Medicare and would not be covered.

Additionally denial could also be the result of same or similar.

My suggestion is in the future provide it as a non covered service when used as you had indicated.

Disclaimer: the aforementioned is information based on my opinion and recollection of past and present similar issues.

Fraternally,

Mark

Mark S. Block, DPM

**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Tuesday, February 8, 2022 2:15 PM
**To:** Mark Block <msb@drmblock.com>
**Cc:** xxxxxx.com
**Subject:** FPMA: Request for a refund from CMS for DME service provided 6/18/2020

Dr. Block,

Dr. xxxxx has requested you by name, for assistance with this situation. I am forwarding his email and attachments.

Submitted for your consideration and reply to Dr. xxxxx .

With Thanks,

Karen Lambert

---------- Original Message ----------

From: xxxx <xxxxxx.com>

To: "klambert fpma.com" <klambert@fpma.com>

Date: February 8, 2022 2:07 PM

Subject: Request for a refund from CMS for DME service provided 6/18/2020

Attention Dr. Martin Block

Dear Dr. Block, At the time of this visit, the ankle gauntlets were dispensed for the purpose of the effect of the neoprene which would redirect the patient's heat back into the feet and Ankles and dilate the vessels going to the nerves. This was using conjunction with a topical relief cream.

A copy of the documents is Attached. Before I pay for this refund, I would like to know if I can defend this charge and not refund the money. Thank you for any help you may provide.

xxxxxxxxx DPM FACFAS
Board Certified ABFAS

## 8)

## Same or Similar issue

Apologies to all. I take responsibility for not following up.

I went back through my emails today to see what happened.

Apparently was lost in the numerous emails I receive daily.

**Dr. xxxxx**

**I suggest you appeal for the reasons he stated.**

**Although I can't guarantee a result, based on my knowledge of these issues there is a high probability that the denial will be overturned.**

**Documentation and diagnosis would be key elements in an attempted positive outcome.**

**As an aside, until the same and similar issue is resolved, these denials are often times a given/"rubber stamp" under these circumstances.**

**Again sorry for the late response.**

Karen

Regarding my Ins. Report, I will try to be brief and just hit on several major accomplishments.

Thanks

MB

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association
Past President Florida Podiatric Medical Association
Chair Emeritus, Health Policy and Practice Committee, American Podiatric Medical Association
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AAPC Certified Surgical Foot & Ankle Coder (CSFAC)
Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com



**From:** klambert@fpma.com <klambert@fpma.com>
**Sent:** Monday, January 17, 2022 6:40 AM
**To:** Mark Block <msb@drmblock.com>
**Subject:** FPMA: Same and Similar Denials

Dr. Block,

We've both had a heck of a lot going on.

Did you already provide an answer for Dr. xxxxx?

If so, would you kindly reforward?

Next, do you have an Insurance Report prepared for General Membership Meeting? How much time should be allotted for delivery?

Thank you.

Sent from my iPhone

Begin forwarded message:

**From:** xxxxx <xxxxxxxx.com>
**Date:** January 16, 2022 at 8:47:16 PM EST
**To:** "klambert fpma.com" <klambert@fpma.com>
**Subject: Re: FPMA: Same and Similar Denials**

Ms. Lambert,

I never heard back from Dr.Mark Block on this. Please advise.

Thank You

On Thu, Jan 6, 2022 at 8:51 AM klambert@fpma.com <klambert@fpma.com> wrote:

Dr. xxxxx,

Thank you for your inquiry regarding same and similar denials. I will be forwarding your email to FPMA Insurance Chair, Dr. Mark Block for review and comment.

Please standby for follow up care of Dr. Block.

Sincerely,

Karen Lambert

On January 6, 2022 9:39 AM xxxxx <xxxxxxxx> wrote:

I recently got denied by insurance for dispensing an L4396 for plantar fasciitis on 12-3-21 because patient received a L1971 on 7-21-21 from another provider. My diagnosis and device is different although the two devices are in the same lower limb orthotic device group. Is an appeal for this denial likely to be won?

**xxxxxxx, DPM**

xxx-xxx-xxxxx

xxxxxxxxe.com

## 9)

Do they have a policy on this procedure?

If so did you comply with the guidelines?

If not, will have to justify with appropriate code if applicable.

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
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AAPC Certified Surgical Foot & Ankle Coder (CSFAC)
Fellow ASPS
Certified Wound Specialist (CWS)
Expert Panelist, Codingline
561-368-3232
Email: msb@drmblock.com



**From:** xxxxxxxxxxxx <xxxxxxxx@yahoo.com>
**Sent:** Friday, February 18, 2022 12:28 PM
**To:** Mark Block <msb@drmblock.com>
**Subject:** humana denial 10061 for paronychia

i got the following denial for 10061. how should i appeal this. how can they say it is not 10061

DOS 05/05/2021. Per review claim was initially paid and payment was recouped from CPT 10061. claim was initially paid later payment was recouped from CPT 10061 as After review of medical record, no supporting documentation could be found to support CPT 10061. Documentation does support for simple I&D procedure and it has been determined that there is amore appropriate code. Therefore CPT 10061 will not be reimbursed for DOS. Rep advised need to bill with appropriate CPT or need to send level 1 dispute with more supporting documents. Claim# 820211270192382.

here is my dictation for exam and treatment

EXAMINATION:

Vascular: Dorsalis Pedis nonpalpable left foot right foot. Posterior Tibial Artery nonpalpable left foot right foot Normal temperature gradient on all areas of the feet. Normal color of both feet. Digital Capillary refill time is normal. Hair growth is absent. Turgor decreased.

Neurologic: Normal Nylon Monofilament test. Vibratory perception testing within normal range. Bilateral normal tactile sensation and Achilles Tendon reflex. No loss of sensation of feet.

Dermatologic:  Left foot toenails are elongated, mycotic, deformed with signs of mild to moderate onychocryptosis, onychodystrophy and subungual debris, discolored yellow, nail plate thickened, onychodystrophic, Nails affected 1 through 5 left, 1 through 5 right. Incurvation deformity is noted along the nail plate along the affected border. There is fluctuance noted along the nail plate along the nail border. mild yellow drainage, moderate edema, moderate erythema, Located right great toe lateral border and There is mild  proud flesh along affected border(s).

TREATMENT:

The following procedure(s) performed today:

Injection given utilizing 5 CC 1% Xylocaine plain in a digital block fashion, to the affected digit. Incision and drainage performed along the right great toe lateral border  from the distal end to the proximal nail fold. Incision and drainage thru the paronycial abscess. Incised proud flesh. Drained abscess. Avulsion of the corresponding nail plate along the right great toe lateral border. Cleanse with normal saline. Apply triple antibiotic and gauze dressing.

Take antibiotics. Follow postoperative instructions.Post operative instructions discussed wtih patient and dispensed in written format (Careplan) to patient.

I chose this Evaluation and Management level which was selected based on Medical Decision Making: Evaluation and management selection based on Number and Complexisty of Problems Addressed:

Moderate

1 acute complicated injury: Paronychia of the right hallux with onychomycosis of the right hallux. 1 or more chonic Illnesses with exacerbation, progression

Onychomycosis with exacerbation.

Risk of complications and/or morbidity or mortality of patient management-moderate risk of morbidity from additional diagnostic testing or treatment Moderate risk with oral medication therefore recommend topical medication for onychomycosis. Moderate risk with surgical procedure I&D PADnet plethysmography testing performed that is medically necessary secondary to significant signs and/or symptoms indicating a high likelihood of limb ischemia, and the patient is a candidate for invasive therapeutic procedure. Claudication less than one-block or of such severity that interfere significantly with the patient's occupation or lifestyle. Significant medical discussion was made regarding his condition of ingrown nail/paronychia. Discussed the diagnosis. Discussed how the ingrown nail can develop or etiologies. These etiologies can include trauma, self cutting of the nail improperly, genetic disposition, tight shoe gear. Treatment options were discussed. Treatment options include just take antibiotics but likely that is not going to be enough. Discussed avulsion of the nail plate along the border discuss incision and drainage. Advantages of the resolution of the pain and infection that may be present. Risk can be return of symptoms postoperative pain. Discussed how to try to prevent recurrence. Answered all of the patient's questions. Discussed about treatment option. Today decision was made for surgical procedure. Discussed treatment options for onychomycosis of affected nails. Discussed oral medication, Lamisil. Discussed that this would require hepatic function panel prior to starting medication. Discussed topical medication. Patient would need to utilize twice daily. Tolcylen, utilize once daily to nails.

Patient wants to have a permanent nail removal of the right hallux that can be done once we have Doppler studies and those are showing adequate circulation so order for arterial Doppler studies.

Dr. xxxxxxxxx

www.xxxxxxxxx.com

## 10)

## Nail debridement LCD question re: documentation and coding

There is an associated article that you apparently missed.

It provides guidance on the ICD10 codes associated with these procedures.

Personally I would also include the appropriate codes that are associated with the verbiage I highlighted in yellow (below LCD section).

Of course your documentation should also indicate that these conditions exist if applicable.

FYI, Medicare has now associated Articles with LCDs to provide guidance on coding etc.

Hope this is helpful.

Fraternally,

Mark

Mark S. Block, DPM, FASPS, CWS, CSFAC
Chair Insurance Committee, Florida Podiatric Medical Association
Medicare CAC/PIAC Representative Florida Podiatric Medical Association

**A57672:**

### Group 1

(26 Codes)

**Group 1 Paragraph**

The following ICD-10-CM codes support medical necessity and provide limited coverage for CPT codes: 11720 and 11721

It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

## Group 1

(26 Codes)

### Group 1 Paragraph

The following ICD-10-CM codes support medical necessity and provide limited coverage for CPT codes: 11720 and 11721

It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

## ICD-10-CM Codes that Support Medical Necessity

**Group 1** (26 Codes)

**Group 1 Paragraph**

The following ICD-10-CM codes support medical necessity and provide limited coverage for CPT codes: 1172

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from

**Group 1 Codes**

| Code | Description |
|---|---|
| B35.1 | Tinea unguium |
| B37.2 | Candidiasis of skin and nail |
| B42.1 | Lymphocutaneous sporotrichosis |
| B42.7 | Disseminated sporotrichosis |
| B42.89 | Other forms of sporotrichosis |
| B42.9 | Sporotrichosis, unspecified |
| B43.0 | Cutaneous chromomycosis |
| B43.8 | Other forms of chromomycosis |
| B43.9 | Chromomycosis, unspecified |
| B44.7 | Disseminated aspergillosis |
| B44.89 | Other forms of aspergillosis |

| | |
|---|---|
| B44.9 | Aspergillosis, unspecified |
| B45.2 | Cutaneous cryptococcosis |
| B45.7 | Disseminated cryptococcosis |
| B45.8 | Other forms of cryptococcosis |
| B45.9 | Cryptococcosis, unspecified |
| B46.3 | Cutaneous mucormycosis |
| B46.4 | Disseminated mucormycosis |
| B46.5 | Mucormycosis, unspecified |
| B46.8 | Other zygomycoses |
| B46.9 | Zygomycosis, unspecified |
| B47.0 | Eumycetoma |
| B48.1 | Rhinosporidiosis |
| B48.2 | Allescheriasis |
| B48.8 | Other specified mycoses |
| B49 | Unspecified mycosis |

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**L33922:**

Expand All | Collapse All

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

Please refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 Foot Care for indications and limitations in coverage for treatment of mycotic nails.

**Covered Indications**

Medicare will consider the treatment of fungal (mycotic) infection of the nails a covered service when the medical record substantiates:

- Clinical evidence of mycosis of the nail, by generally accepted clinical findings such as discoloration, onycholysis, subungual debris, thickening, or secondary skin infection;

In addition one of the following must be documented for mycotic toenails:

- the ambulatory patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate(s); or
- the non-ambulatory patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate(s).

Appropriate anti-fungal treatment is necessary to qualify nail debridement as a medically necessary and reimbursable service unless contraindicated. If an anti-fungal treatment is not used, the contraindication must be documented in the medical record.

Patients need not have an underlying systemic condition to be covered for mycotic nail care.

**Limitations**

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

**From:** klambert fpma.com <klambert@fpma.com>
**Sent:** Sunday, February 20, 2022 4:15 PM
**To:** Mark Block <msb@drmblock.com>
**Subject:** Fwd: Nail Debridement Questions

Dr. Block,

Dr. xxxxx poses a question below. Are you able to assist him with his coding question?

With Thanks,

Karen Lambert

---------- Original Message ----------

From: xxxxxxxxxx<xxxxxxxxx.com>

To: "klambert fpma.com" <klambert@fpma.com>

Date: February 20, 2022 12:58 PM

Subject: Nail Debridement Questions

Ms. Lambert,

when performing nail debridement (CPT: 11720-11721) for mycotic nails (not Routine Foot Care) the FirstCoast LCD L33922 states I must document nails affected, clinical evidence of mycosis, manner in which debrided, and use of appropriate antifungal or contraindication to treatment. However, I must also describe the qualifying symptoms for debridement. The LCD does not state what these "qualifying symptoms for debridement of toenail(s)" are. Based on prior APMA lectures, I am assuming this "qualifying symptom" is pain in toe(s). Assuming this is true, do I also have to add ICD M79674 or M79675 (Pain in right toe(s); Pain in left toe(s)) to the claim? Or is just writing in my encounter note that there is pain in the toe appropriate?

Thank You!

xxxxxxxxxxxxxxxxxxxxxx

**xxxxx DPM**
xxx-xxx-xxxx
xxxxxxxxxx

# VII

# Accomplishments

**1)**

**Parity for First Coast Provider**

For many years, providers with First Coast Service Options Inc., the Medicare administrative contractor for jurisdiction N, which includes Florida, Puerto Rico, and the US Virgin Islands, were required to list the MD, DO, PA, or NP who diagnosed a non-asterisked complicating condition that qualified a patient for routine foot care coverage. Thanks to advocacy efforts led by Florida Podiatric Medical Association CAC Representative Mark Block, DPM, First Coast has reversed this longstanding policy in an updated Local Coverage Article by allowing podiatrists to serve as providers who diagnose a non-asterisked complicating condition that qualifies a patient for routine foot care coverage.

**2)**

## Anthem -59 Modifier Policy Victory and CMS Advocacy Update

Anthem has agreed with APMA's recommendation to fix its At-Risk Foot Care and -59 Modifier Coding Policy. In a recent meeting, Anthem representatives stated the new policy permits paring of calluses (CPT 11055-11057) and debridement of a toenail (CPT 11720/11721) when performed on the same toe if the pared callus was unrelated to and not contiguous with the debrided nail and the callus paring and nail debridement were distinct, unrelated procedures, even when performed on the same toe. This policy became effective on July 25, 2021. APMA also met with CMS in August requesting that the NCCI update its 59 Modifier Policy.

**3)**

## New Guidance on Surgical Treatment of Nails for Those Who Serve Novitas and First Coast Beneficiaries

Updated Nail Avulsion Policies for Medicare Contractors Novitas and First Coast Services released and take effect January 30, 2022. When these identical policies were first proposed, repeat nail avulsion on the same toe less than eight months following a previous avulsion and repeat nail excision of the same toe were to be never allowed. Those proposed limitations were amended thanks to the advocacy efforts from APMA and Novitas and First Coast CAC Representatives.

***The information contained in this report is provided in an effort to assist the membership and is based upon current information available. Every attempt was made to provide accurate information and guidance. It is to be understood that some of this information is based upon my interpretation and understanding at the time of this submission.***

***Material contained in this report, where applicable, should be confirmed with carriers, appropriate agencies and/or referenced sources regarding policies and relevant information. Additionally, some of the material is based on research and when contained in public forums the assumption was made that it was available for further access through this publication for informational purposes only.***

***Mark S. Block, DPM***
***Insurance Chairman FPMA***