A Little Bit of This, A Little Bit of That

These Q & A's recently appeared on Codingline.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

Medicare & Foot Orthotics

Question: *My biller sent in a claim for foot orthotics (L3000 x2) to Medicare and received payment. I told him that foot orthotics are not covered by Medicare [unless the shoe is attached to a brace], which is what the DME gurus have always assured us. He said he called Medicare and even talked to a supervisor who assured him that it was a legitimate payment. Has anything changed with Medicare regarding orthotics lately?*

Answer: Nope. Foot orthotics are statutorily non-covered. The Medicare Benefit Policy Manual Chapter 15 (Covered Medical and Other Health Services), Section 290: Foot Services; Exclusion of Coverage; 3. Supportive Devices for Feet states: "Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics."

So, unless you are dispensing Forrest Gump's shoe-braces, don't expect Medicare to reimburse you for the foot orthotics. Please note that if Forrest was on Medicare and only had a single leg brace, only one foot orthotic would be covered.

So, when a Medicare patient calls Medicare and comes to you saying, "Why, even the Medicare rep says foot orthotics are covered," you can say, "Is that so? You say it is and I say it isn't. Maybe you're right, but I don't think so. Are you a gambling [man, woman]? Sign this Advance Beneficiary Notice of Non-coverage (ABN) just to confirm that you were told that you would in all likelihood be responsible for payment. Notice where it says that I may be asked to be paid now. "How would you like to pay for the foot orthotics, credit card, check, or cash?"

Foot orthotics are statutorily non-covered.

Submit a claim to your DMAC for L3000-RT and L3000-LT with the addition of "GY" modifiers on both codes to ensure you will get a denial from Medicare (take that, Medicare rep). The "GY" is described as "Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.

By the way, every once in a while, an office bills L3000-RT and L3000-LT wrong to Medicare. It seems some offices are so programmed to add a "KX" modifier to therapeutic shoes, without thinking, they include a "KX" modifier to each of the foot orthotic codes (e.g., L3000), forgetting what the "KX" actually tells Medicare's computers: "Requirements specified in the medical policy have been met." Oh, really? I don't think so. At least not too often, like one in a million. I think it is safe to assume that you will only temporarily be holding onto Medicare's money before they send you a nasty-gram.

Pearl: It is highly unlikely you will have patients who qualify for custom foot orthotics (e.g., L3000) under Medicare Part B…ever. If you want to bill a Medicare patient for custom foot orthotics, use code CPT CASH.

I&D of Abscess

Question: *I billed the following to a commercial payer:*

CPT 10061-T5
CPT 10061-T5-59
CPT 10061-TA-51
CPT 10061-TA-51-59

but the insurance company paid for

Continued on page 64

A Little Bit *(from page 63)*

only one toe side. Is this correct? Can we appeal this? Would the billing change if this was Medicare?

Answer: These questions are interesting on so many levels. The responses on Codingline pretty much followed the wisdom imparted by Paul Kinberg, DPM, CSFAC: "The CPT 10061 description is 'incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple." The operative word in the descriptor is 'multiple.' That means regardless of how many I&Ds you performed, you can only bill for and be paid for one service. I believe if you appeal, you would most likely lose. Also, because this denial was based on the code verbiage, it would not matter which insurance company was involved."

Who can argue with Dr. Kinberg's reasoning? Well, playing devil's advocate, I have some questions: Since the CPT 10061 description says "complicated or multiple", one may presume that CPT 10061 is the one and only ultimate cutaneous I&D of abscess code that can be billed once per session/day. You would never also bill CPT 10060 since it would fit into the "multiple" description of CPT 10061, right? Hmmm. Are you sure? In real terms, if a doctor performs three or four cutaneous "complicated" I&Ds of abscess (remember that an abscess is a collection of pus; you don't I&D a paronychia or onychia), he/she will get the same reimbursement as a colleague who performed a single cutaneous abscess "complicated" I&D. Is that reasonable or fair? I, for one, think not.

For the record, CPT 10060 value in total non-facility RVUs is 3.33 (1.22 work RVUs), while CPT 10061 value total non-facility RVUs is 5.86 (2.45 work RVUs).

So, I have two questions:

Question 1) Since CPT 10060 is described as "simple or single", why can't you bill multiple CPT 10060s, one for each simple abscess I&D performed in a single session?

Medicare has assigned 1 MUE (Medically Unlikely Edit) to the code (just like CPT 10061). But MUE is specific to Medicare. Non-Medicare payers have their own proprietary payment limits. But why should one assume that the intent of CPT was to include multiple CPT 10060 within the definition of CPT 10061? Keep in mind, CPT, which does not deal in value or payments, does not include language (guidelines or instructional) within it that states that multiple CPT 10060 performance is defined under CPT 10061's "multiple" description.

CPT Assistant, the official clarifying publication for CPT, did try to answer that question. In *CPT Assistant,* Special Issue 2005, page 7: *"Question:* If an incision and drainage is performed for one abscess on the arm and one on the leg, would it be appropriate to report code 10060 two times? Or should code 10061 be reported one time?

Regardless of how many I&Ds you performed, you can only bill for and be paid for one service.

AMA Comment: Many of the incision and drainage (I & D) procedures include one code for simple procedures and one code for complicated procedures; however, the terms simple and complicated are not defined in the CPT codebook. Rather, the choice of code is at the physician's discretion, based on the level of difficulty involved in the incision and drainage procedure. It is important to note that code 10060, incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single, should be reported for a simple or single I & D procedure.

Code 10061, Incision and drainage of abscess ("e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple, should be reported for a complicated or multiple I & D procedure.")

My takeaway is that simple. I&Ds should be billed under CPT 10060, while complicated I&Ds should be billed under CPT 10061. You, however, might feel otherwise. You might feel it is okay to commingle the two codes, mixing and matching, but never beyond a single CPT 10061. And that's okay since ultimately, the payer will decide for you.

Question 2) It has probably been decades since CPT 10060 and CPT 10061 were introduced. One would think the language would have been made clearer over the years, but it hasn't. So, my question is, what is the difference between a "simple" and a "complicated" incision and drainage of a cutaneous abscess?

Other than guessing, can anyone define the difference? Over the years, I heard everything from, if it is a large abscess, it is complicated; if it requires local anesthesia, it is complicated; if it requires a trip to the OR to take care of it, it is complicated; if I say it is complicated, it is complicated. The problem is that CPT doesn't help us at all. Even *CPT Assistant* refuses to define the difference, leaving it to "physician discretion" which is ridiculous since everyone knows physicians have no discretion…only payers do.

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Continued on page 65

A Little Bit *(from page 64)*

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.