No Such Thing as Routine Foot Care

At-risk care saves limbs and lives.

BY MICHAEL J. KING, DPM

Routine foot care is a term most billing and coding authorities hate. Many are not fans of "conservative" care and prefer non-surgical care. Sure, some things may appear routine to the insurance world (Medicare's term) but in the case of the at-risk patient, it is certainly NOT routine. Sometime back at an APMA House of Delegates meeting, Dr. Ken Malkin, delegate from NJ, noted the term "at-risk foot care" … a much more appropriate term; and it has started to stick.

At-risk foot care may seem like a mundane task to many, but to the patients who are at risk, it is a critical element to their well-being. Every major payer in America knows how critical it is to the value of healthcare and its importance to adding to that value through risk reduction.

So many of our colleagues live in the CPT 11721 world: Debridement of nail(s) by any method(s); six or more. Sure, many if not most of our patients have truly mycotic nails but how many really have 10? This code is highly scrutinized, right or wrong, so let's discuss some options for better, correct coding and perhaps to help keep you off the radar of your Medicare MAC. Too many audited charts have CPT 11721 for every at-risk patient seen in a practice.

Most of us in the coding world feel that those dystrophic nails we see in combination with a skin lesion are sometimes mycotic, but often just crappy nails with dystrophic changes. So, here are a couple of coding scenarios to keep in mind. Instead of just circling or entering into your EMR, 11721 for every at-risk patient that comes in, think about the lesions you see and the dystrophic nails you are treating. Many of our colleagues just mark off the 11721 to get out of the room, get the bill out, etc. and feel that if they bill for the at-risk lesion, it will get blown off by the carrier. Correct and accurate coding is the key to reimbursement as is the documentation to match the findings. Here are a couple of scenarios for your thoughts.

A patient presents with a HD dorsal 2nd toe right foot, dystrophic nails across the board (some mycotic), and has class findings present, let's say qualifying as a Q8, an at-risk patient. Instead of just billing out a 11721 and calling it a day, try this:

CPT 11055, Q8 (for the lesion debridement on the dorsal PIPJ) Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); *single* lesion

CPT 11720, 59, Q8 for the 3 or 4 mycotic nails: Debridement of nail(s) by any method(s); *one to five* and…

G0127, 59, Q8 for the dystrophic nail care: Trimming of dystrophic nails, *any number*

Many if not most of the patients who are at-risk have such findings or very similar, versus the daily 11721 all-day-long scenario. Not only is this likely a much more accurate coding scenario but it can enhance your revenue stream legitimately. On top of that, you will now no longer be

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living in a one-code world, one that is constantly questioned. You will also be more realistically coding and showing the true value of at-risk care to the payer world.

What may seem routine to many is truly potentially limb-sparing for others. Don't undervalue your services to these patients or to yourself.

We now have a whole new issue with the use of 1105x and 11721 or 11720 based upon the location of the lesion. You are encouraged to follow the APMA information on those codes in combination. It is based more on those DIPJ or distal skin lesions, not the scenario presented above. Those circumstances, however, should not dictate proper coding or being scared off in the proper use of the codes when appropriate.

The importance of documentation for such conditions cannot be overemphasized. As those of us in the auditing part of coding see all too often, the notes do not reflect the care and they must. As most of us are using EMR systems now, it is quite easy to take the time to develop macros which can be adjusted at the time of each visit to reflect the changes seen in these at-risk patients. If we are always living inside one code, again picking on CPT 11721, we will remain on the outside of truly picking up these value-based issues and being the leaders in directing their care plans. You don't really think the PCPs have the knowledge or the time to be seeking out each of these problems, do you? Thus it is up to us.

This does not mean advocating for billing for what you don't see but being cognizant of the reality of coding and what we are seeing. As the value-based world of medicine increases, it is critical that the DPM is seen as the quarterback for these plays and at-risk conditions. What may seem routine to many is truly potentially limb-sparing for others. Don't undervalue your services to these patients or to yourself. **PM**

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