Nail Debridement Plus Callus Paring Issues

Here's an update.

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Chapter 3, Section E, Example 3 of the National Correct Coding Initiative Policy Manual for Medicare Services[1] states:

"NCCI has a PTP edit with Column One CPT code 11055 (Paring or cutting of benign hyperkeratotic lesion...) and Column Two CPT code 11720 (Debridement of nail(s) by any method; 1 to 5). Modifier—59 or—X{EPSU} shall not be used to bypass the edit if these two procedures are performed on the same distal phalanx, including the skin overlying the distal interphalangeal joint."

Therefore, nail debridement (CPT® 11720/11721) and callus paring (CPT 11055-11057) may not both be submitted if the callus(es) pared were on the same distal phalanx of a toe whose toenail was debrided. While this policy in the National Correct Coding Initiative Policy Manual for Medicare Services[1] only applies to Medicare beneficiaries, many non-Medicare third-party payers adopt this same language.

Problem #1

This policy does not make sense and restricts access to medically necessary care, which can increase risk for complications, including amputations that carry high rates of morbidity and mortality. This policy inappropriately bundles two unrelated services performed at separate anatomic sites—services with no overlap in time, work, risk, instrumentation, or cost that are performed on unrelated, non-contiguous lesions in separate anatomic locations. Especially troubling is the fact that one of the services that this policy speaks to is the paring of calluses, which are pre-ulcerative lesions. When not properly cared for via paring or cutting, these pre-ulcerative lesions can lead to costly amputations that carry with them incredibly high rates of morbidity and mortality.

Multiple efforts have been made to overturn this policy. American Podiatric Medical Association representatives have had multiple meetings with different Medicare representatives and explained the dangers associated with this policy. Since advocacy efforts were successful in easing this restriction so that it involves only the distal phalanx instead of the entire toe in 2018, no further changes have been made by Medicare. Efforts continue to overturn this egregious policy.

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Problem #2

Even for those payers that follow the policy outlined above, coverage should exist for calluses pared that are not on the same distal phalanx of a toe on which the toenail was debrided. However, there are third-party payers that have, based on this policy, inappropriately built edits that result in denials when any combination of nail debridement and callus paring are submitted, regardless of the location of those calluses that were pared. This results in widespread denials when calluses are pared nowhere near the distal phalanx, such as the plantar forefoot or lateral midfoot.

Payers have responded to advocacy efforts to delete these inappropriate edits by referencing poor provider documentation. Payers largely understand that coverage should exist for calluses pared that are not on the same distal phalanx of a toe on which the toenail was debrided. However, in many instances, provider documentation does not indicate if the calluses pared were on the same distal phalanx of a toe on which the toenail was debrided or not. Many of these payers substantiate the existence of these inappropriate edits using examples of documentation of callus paring that does not indicate whether the callus(es) pared were on the distal phalanx or not. Examples of this poor documentation include:

"Calluses pared X 3."

"Calluses pared right foot toes 2,3,4."

"Three calluses on the left and one callus on the right pared."

None of these documentation examples indicate whether the calluses pared were on the distal phalanx or not.

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What to Do About Problem #2

It is essential that provider documentation indicate the exact location of calluses pared and whether or not those calluses were on the same distal phalanx of a toenail that was debrided. Ensuring that provider documentation is more frequently precise will help in discussions with third-party payers that have built these edits and use the explanation of poor documentation to support them. An example of documentation that details the exact location of calluses pared is:

"Calluses on the dorsal proximal interphalangeal joint of the right 2nd toe and central plantar right heel were pared. Neither of these calluses are on the same distal phalanx of a toe that had a toenail debrided."

When there are inappropriate denials when the documentation does precisely indicate the location of calluses pared and those calluses were not on the same distal phalanx of a toenail that was debrided, it is suggested that providers contact their administrative defense coverage carrier for assistance in combatting these inappropriate denials. The American Podiatric Medical Association has a created a wealth of resources to assist members with this exact problem. These resources can be found at apma.org/59Mod. One of the many valuable resources found here is a template appeal letter for APMA members to consider using when documenting properly yet still experiencing these inappropriate denials.

Conclusion

Advocacy efforts, led by the American Podiatric Medical Association, continue to attempt to both change the language in Chapter 3, Section E, Example 3 of the National Correct Coding Initiative Policy Manual for Medicare Services[1] and also combat inappropriate edits that have been built based upon that language. An essential element of succeeding with the efforts to stop the inappropriate edits is providers appropriately documenting the exact location of calluses pared. Until changes are made to either the policy and/or the inappropriate edits developed as a result of that policy, providers are encouraged to appeal inappropriate denials if their documentation is accurate and use the assistance of their administrative defense coverage carrier and the other resources outlined in this article. **PM**

Reference

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