Podiatry Coding Tips

Biopsies
Whether for skin, bone, or nail, biopsies are only reportable if the sole purpose of the procedure is to remove a sample for biopsy. Combinations such as a therapeutic nail debridement (11721) along with a nail biopsy (11755) should not be billed if the biopsy is being taken from the debrided sample.

Routine Foot Care Coverage
Most insurances have very limited coverage for routine foot care, including nail debridement and lesion removals. For these items to be covered by Medicare, the below conditions must apply:

- When reporting PVD for routine foot care, use diagnosis code 443.89
- When reporting diabetes for routine foot care, use diagnosis codes 250.40 – 250.73
- Routine foot care codes are only payable once every 60 days or 9 weeks
- If reporting diabetes as a diag, you must include the date last seen by the PCP
- Nail Debridement (11720, 11721)
  - Primary diagnosis must be either:
    - 110.1 Onychomycosis of nail
    - 703.8 Onychauxis of nail
  - Secondary diagnosis must one of the following:
    - 681.10 Unspecified cellulitis and abscess of toe
    - 681.11 Onychia & paronychia of toe
    - 703.0 Ingrown nail
    - 719.7 Difficulty walking
    - 729.5 Limb pain
    - 781.2 Gait abnormality
- Lesion Removal (11055, 11056, 11057)
  - Requires a Q7, Q8, or Q9 modifier
  - A systemic disease such as diabetes or PVD should be the primary diagnosis
  - Example secondary diagnosis codes that are usually payable include:
    - 701.1 Keratoderma
    - 700 Corns & callosities
    - 729.5 Limb pain
Coding by Size
Certain procedures are coded based on size of the treated area rather than the location. When reporting these procedures, please use the guidelines below to select your codes, or include the treated size on your superbill.

❖ Debridement, subcutaneous tissue
  o 11042 for the first 20 sq cm of treated area
  o 11045 for each additional 20 sq cm
❖ Debridement, muscle and/or fascia
  o 11043 for the first 20 sq cm of treated area
  o 11046 for each additional 20 sq cm
❖ Debridement, bone
  o 11044 for the first 20 sq cm of treated area
  o 11047 for each additional 20 sq cm
❖ Debridement including topical application, wound assessment
  o 97597 for the first 20 sq cm of treated area
  o 97598 for each additional 20 sq cm

Physical Therapy
While each insurance maintains different coverage guidelines for physical therapy, most procedures are reported based on time rather than location. For example, if electrical stimulation is performed for five minutes on each foot, only one unit of 97032 should be reported. If a total time exceeding 15 minutes is performed, than additional units can be reported. Codes such as 97010 are generally only reportable once regardless of time or location, unless the patient is treated in multiple sessions on the same day.

❖ 97032 Electrical stimulation, one or more areas, each 15 minutes
❖ 97035 Ultrasound, one of more areas, each 15 minutes
❖ 97110 Therapeutic exercise for strength, endurance, ROM, one or more areas, each 15 minutes
❖ 97010 Hot or cold packs, one or more areas
❖ 97012 Mechanical traction, one or more areas
❖ 97014 Electrical stimulation (unattended), one or more areas
❖ 97022 Whirlpool, one or more areas

Toe Modifiers
When reporting procedures on individual toes, please include the exact toe using billing modifiers or R1, R2, L1, etc. Reporting toe procedures with only RT or LT can result in a denial. Common procedures that should be reported with toe modifiers include 11730, 11732, 11750, and 28285.

Ultrasound Guidance
Procedures such as 76942 are only reportable once per encounter, regardless of how many injections are performed.