Billing, Coding, Auditing, Revenue Cycle Training by BCA

Tough Topics in FQHC

Foot and Wound Care

Effective April 2022

Agenda

- Incident-To Basics
- Foot Care Guidelines
- Documentation Essentials
- Reporting Wound Care
- Documentation Troubles
- Reporting Additional Concerns

Incident-To Basics

1. Service must meet all incident-to criteria
2. Initial visit rendered by ordering practitioner
3. Within the scope of practice for service provider
4. Part of normal course of treatment
5. Physician involved – direct supervision
6. Payer must accept – check with top payers
7. Billed under supervising physician/OQHP

Part B Medicare 99211 Definition

Services billed to Medicare under CPT 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury.

The evaluation is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information.

The encounter must include elements of both evaluation and management.

The management portion is substantiated when the documentation demonstrates an influence on patient care.

The FQHC/RHC Medicare rule: 99211 is not a ‘visit.’

Payments from the Medicare program for FQHCs/RHCs are per the PPS or AIR methodology.

A “visit” is defined as a face-to-face encounter between a patient and a physician, NP, PA, CNM, CP, CSW, or visiting nurse (very limited cases in the home) during which an RHC or FQHC service is rendered.

A ‘Nurse Visit’ may and should be coded and counted in the FQHC is not be billed as an “encounter” to Medicare.

- Check with your state Medicaid for FQHC/RHC guidance.

Noridian Guidance

Code	Description
11719	TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER
11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5
11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE
G0127	TRIMMING OF DYSTROPHIC NAILS, ANY NUMBER

Class Findings

Group 1 Paragraph:

For purposes of applying presumption of coverage, when the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement, the following findings are pertinent:

- Class A Findings:
  - Nontraumatic amputation of foot or integral skeletal portion thereof.
- Class B Findings:
  - Absent posterior tibial pulse;
  - Advanced trophic changes as: hair growth (decrease or absence) nail changes (thickening) pigmentary changes (discoloration) skin texture (thin, shiny) skin color (rubor or redness) (three required); and
  - Absent dorsalis pedis pulse.

- Class C Findings:
  - Claudication;
  - Temperature changes (e.g., cold feet);
  - Edema;
  - Paresthesias (abnormal spontaneous sensations in the feet); and
  - Burning.

Group 1 Modifiers

Group 1 Codes:

CODE	DESCRIPTION
Q7	ONE CLASS A FINDING
Q8	TWO CLASS B FINDINGS
Q9	ONE CLASS B AND TWO CLASS C FINDINGS

Group 2 – Carefully review diagnosis options

Group 2 Paragraph:

The ICD-10-CM codes below represent the diagnoses where the patient has evidence of neuropathy, as demonstrated by methods such as the Semmes-Weinstein filament, but no vascular impairment, for which no class findings modifiers are required.

One of the Group 1 ICD-10-CM codes above **MUST** be billed as the *primary* diagnosis to ensure payment.

Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation:

When the patient's condition is one of those designated by an asterisk (*), routine procedures are covered only if the patient is under the active care of a Doctor of Medicine or Osteopathy. They must document the condition of the complicating disease process during the 6-month period prior to the rendition of the routine-type services per MLN Matters® Number: SE1113.

Group 3 – Refer to Class Modifiers

List of diagnosis where the pt has evidence of vascular impairment

Class modifiers are required

If pt's qualifying condition is marked by an asterisk, routine procedures are covered only if the pt is under active care of a Doctor of Medicine or Osteopathy (MD or DO).

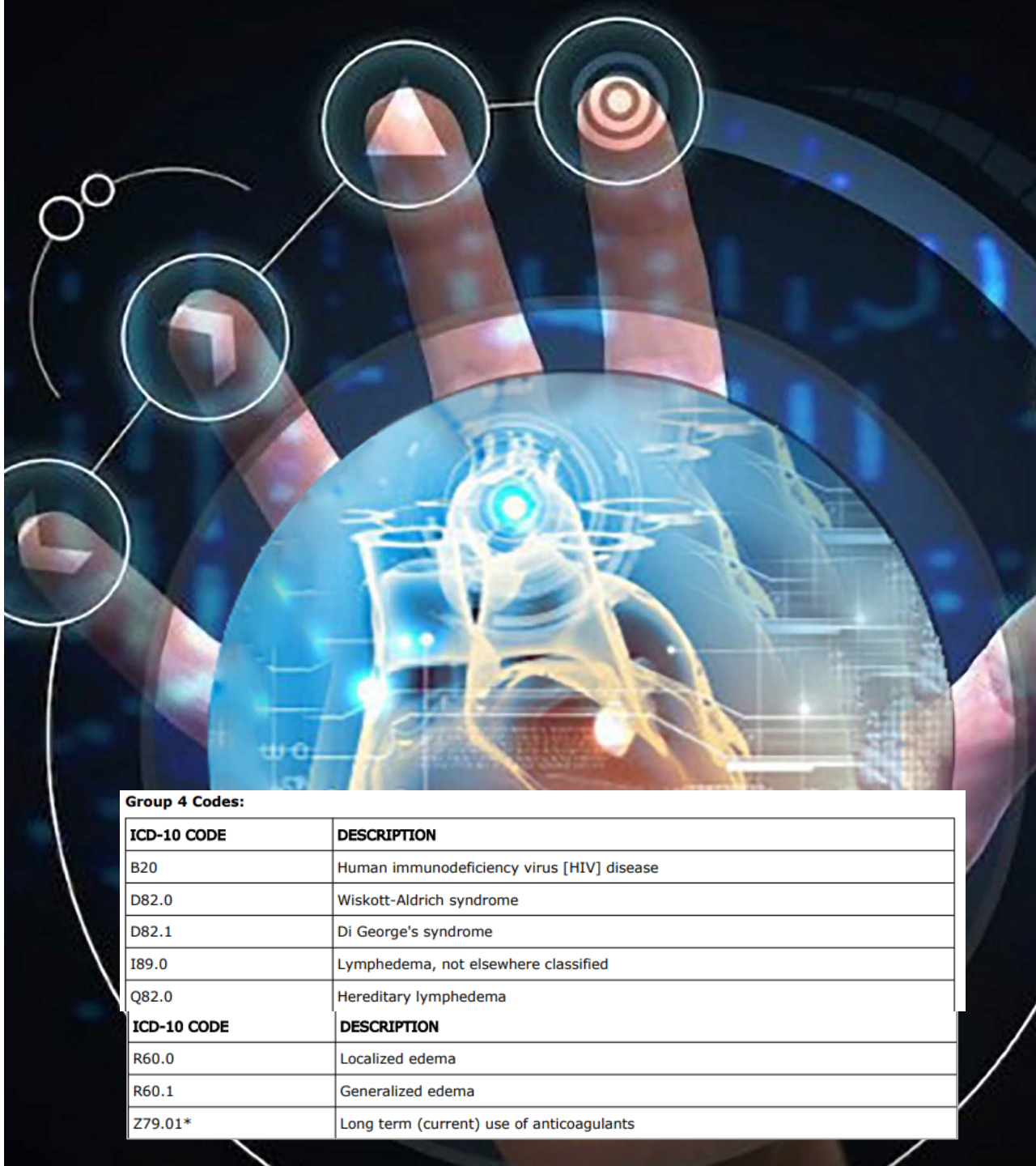
See MLN Matters SE1113

Group 4

Pt has no neurological or vascular impairment

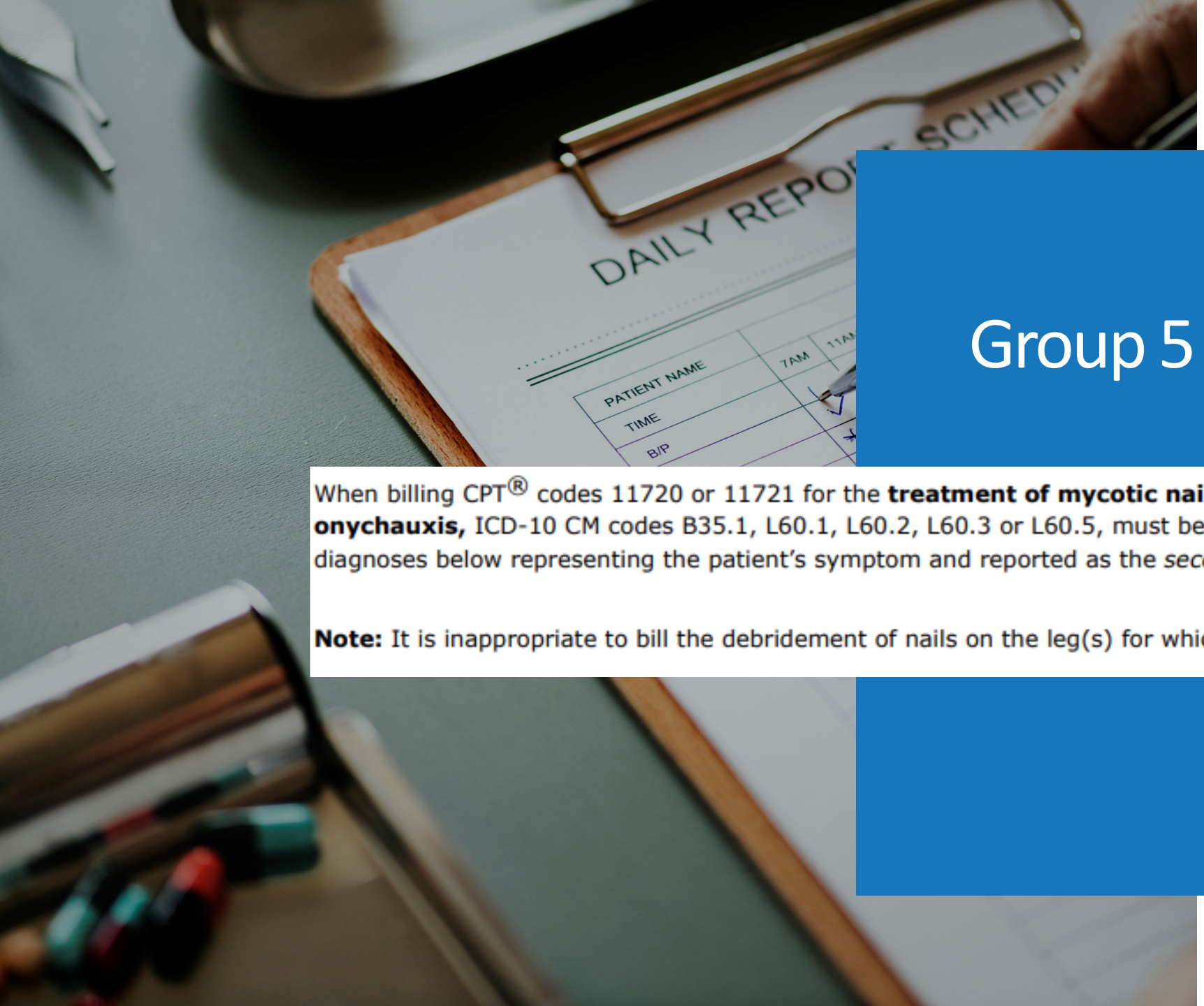
Must use Group 1 code as primary, followed by Group 4 code

If designated by an asterisk, must be under active care of DO or MD



Group 4 Codes:

ICD-10 CODE	DESCRIPTION
B20	Human immunodeficiency virus [HIV] disease
D82.0	Wiskott-Aldrich syndrome
D82.1	Di George's syndrome
I89.0	Lymphedema, not elsewhere classified
Q82.0	Hereditary lymphedema
ICD-10 CODE	**DESCRIPTION**
R60.0	Localized edema
R60.1	Generalized edema
Z79.01*	Long term (current) use of anticoagulants



Group 5

When billing CPT® codes 11720 or 11721 for the **treatment of mycotic nails, or onychogryphosis, or onychauxis,** ICD-10 CM codes B35.1, L60.1, L60.2, L60.3 or L60.5, must be reported as **primary**, with one of the diagnoses below representing the patient's symptom and reported as the *secondary*.

Note: It is inappropriate to bill the debridement of nails on the leg(s) for which a patient has a prosthetic limb(s).

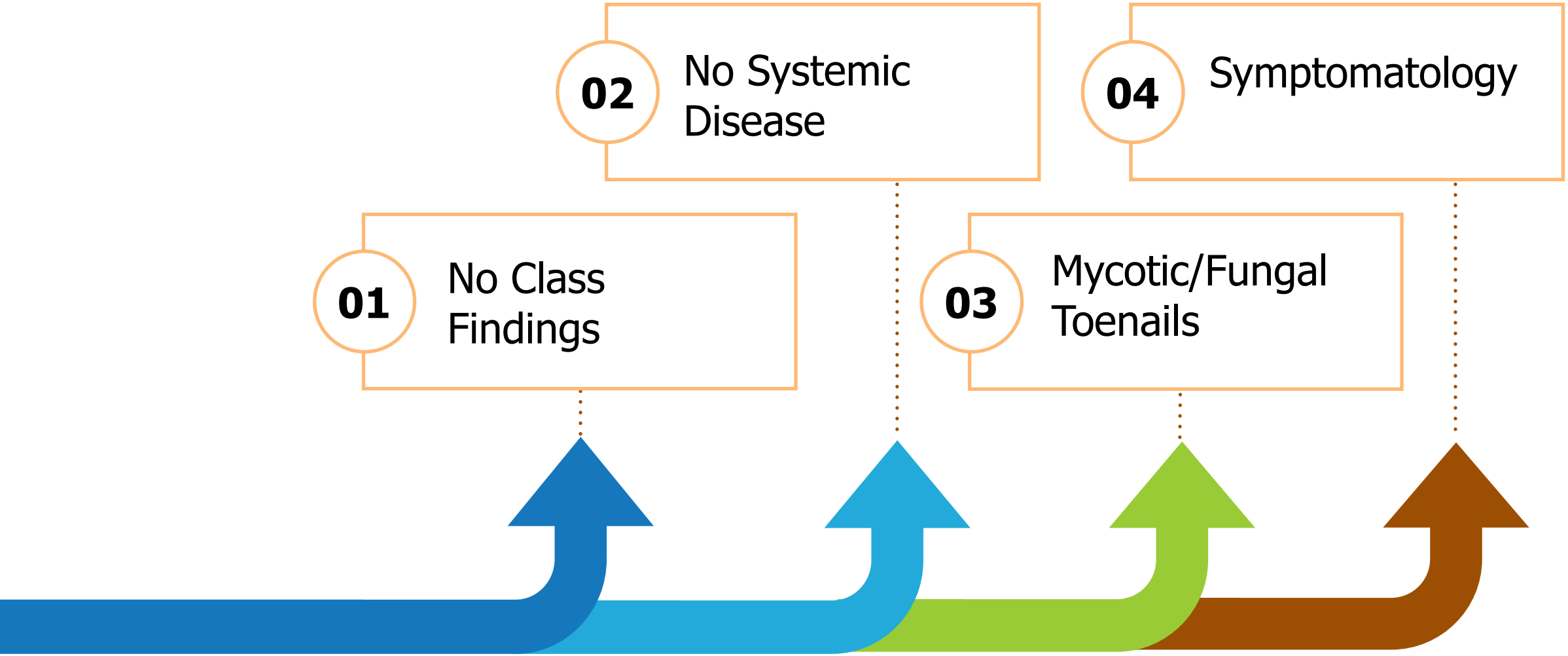
Documentation Components

01 If being carried out under a standing order, reference the date of the SO, today's exam findings, and clear procedure performance with pt tolerance and instructions.

02 If incident-to today's E/M service, ensure appropriate diagnoses are represented, clearly document performance of procedure, tolerance, instructions.

“Otherwise Health Individuals”

To qualify for routine foot care for those not “At Risk”



Document for EACH of the affected toenails:

- Pain and/or
- Secondary infection and/or
- Marked limitation of ambulation and

- Clinical findings indicating fungal infection:
  - Thickness
  - Discoloration
  - Odor
  - Texture
  - Subungual Debris
- Active Treatment Plan

Tips for Great Documentation

01 All the affected toenails need to be identified

02 Thorough description of fungal infection for all the affected toenails

03 Secondary qualifying diagnosis (pain, difficulty w/ambulation, etc.) for all the affected toenails

04 Instrumentation used

05 Include the word “Debridement”

Wound Care CPT Coding

01 99211 is an excellent option when properly documented

02 Other options (such as nonselective debridement codes) may be available based on level of training/licensure and payer policy.

Ground Rules for 99211:

Typically, 99211 is a face-to-face encounter, but allowed via telehealth during the PHE.

The ordering practitioner has conducted the initial visit for the condition and established a treatment plan with an order for the incident-to service.

COVID specimen collection is the exception (for Medicare)

A supervising clinician must be in the office (or available via audio-visual during PHE) at the time of the nurse encounter. [Part B Medicare specific].

Evaluation of a new problem by clinical staff is not an incident-to service.

Ground Rules for 99211:

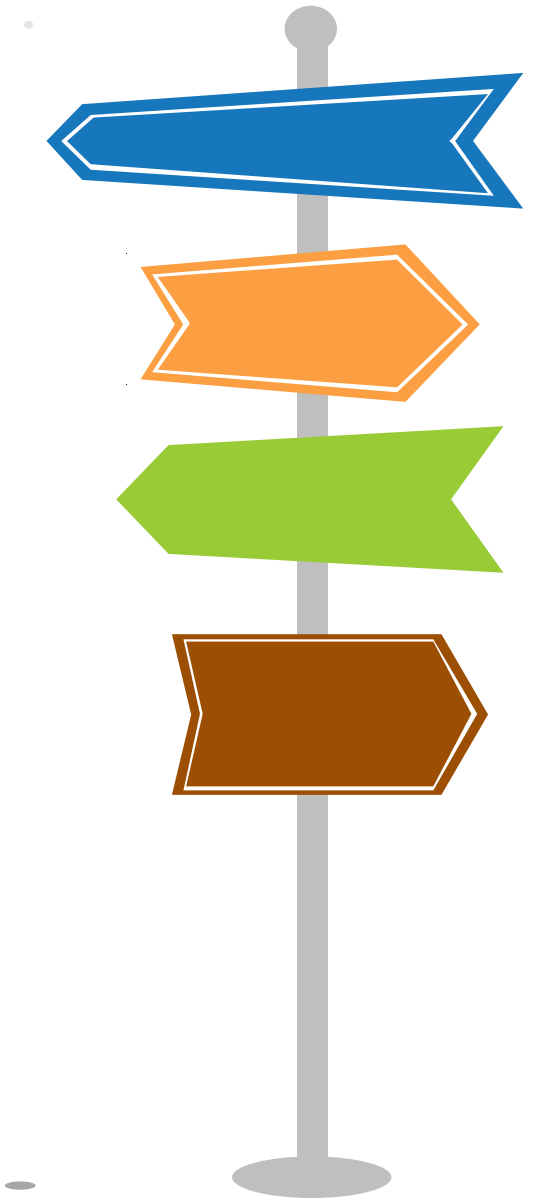
The service must be medically necessary and usual course of treatment

Service is within the performer's "scope of practice" and in accordance with state laws.

Nursing documentation should reflect:

- The order
- The reason for the service (diagnosis)
- Nursing assessment as indicated
- Nursing action as indicated
- Patient instructions
- Follow-up
- Nurse's legible SIGNATURE and credentials

Signed off by the supervising physician/practitioner.



Billed as 99211: How's the documentation?

9/6/21: Pt here in office. Bilat LE edema has improved. Weight 146 lbs., BP 122/68, RR 16, HR 80. Sent to lab.– J. Jones, RN

1. The order
2. The reason for the service (diagnosis)
3. Nursing assessment as indicated
4. Nursing action as indicated
5. Patient instructions
6. Follow-up
7. Nurse's legible SIGNATURE and credentials

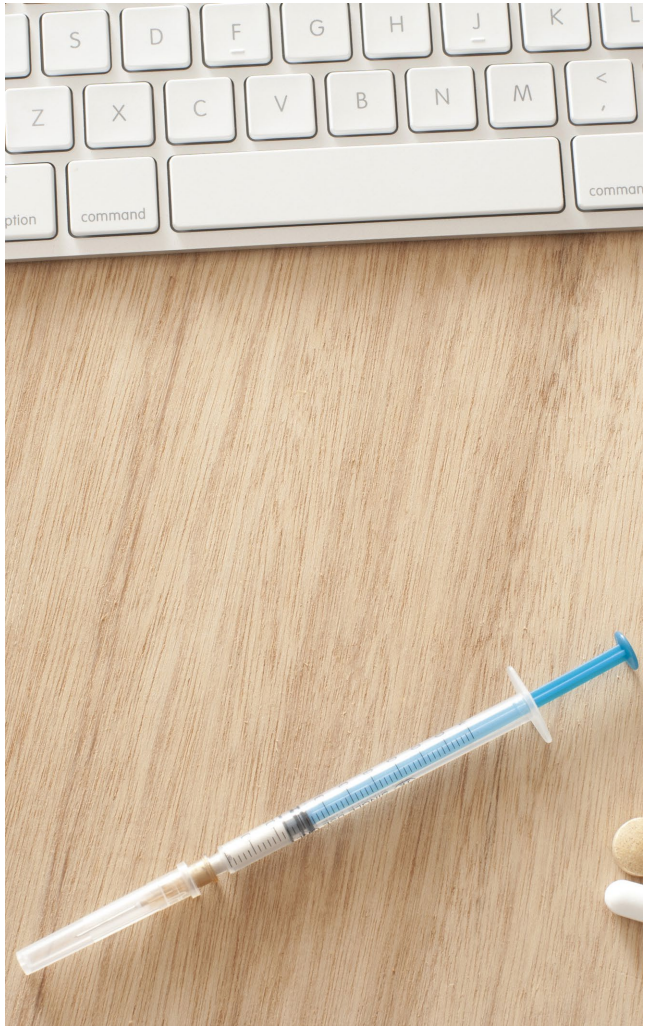
99211? It depends on the documentation!

9/10/21: Blood Pressure recheck, 130/76. Improved from previous visit. Confirmed taking meds as directed.
-S. Hunter, LPN

9/10/21: FU BP
Patient is here for HTN follow-up per the request of Dr. Smith. Pt was started on a new antihypertensive 2 weeks ago. Confirmed taking medication as directed. He denies chest pain, SOB, cough, and vision changes. BP today is 130/76, improved from 160/100, wt unchanged from 180 lbs. Lungs are clear, heart RRR, no ankle edema. We reviewed his meds and diet plan. He will return as scheduled or call with any problems. Dr. Smith is onsite and informed of today's results. S. Hunter, LPN

99211? It depends on the documentation!

9/20/21: Wound examined, rebandaged. Results relayed to Dr. Smith. Finish antibiotic.
S. Jones, CMA



9/20/21: Follow-up cellulitis
At the request of Dr. Brown, pt is seen in f/u for cellulitis dx'd on 9/15 . Temp and other VS entered and are WNL. Patient states ankle pain is much improved. Notes some itching, as expected, but no streaking or warmth. Still taking antibiotics; taking as directed. States feeling much better. Exam of affected area shows significant improvement. Cleaned and rebandaged wound.
Results shared w/ pt and Dr. Smith, onsite supervising physician. Nursing education completed, and instructions given. Pt will return PRN.
S. Jones, CMA

Will Your Documentation Support 99211?

EVALUATE YOUR PROCESS AND DOCUMENTATION:

1. Does the documentation identify the ordering/supervising physician?
   "Direct supervision" means the physician must be physically present in the office suite or available via audio-visual communication during PHE.
2. Does the documentation identify the order?
3. Does the documentation identify evaluation and management?
4. Does the documentation identify the nurse with credentials?

Will Your Documentation Support 99211?

Evaluate your process and documentation:

05 Does your process identify the physician's involvement?

- Results and/or nursing information relayed to physician?
- Sign-off by the supervising physician/practitioner?

06 How often is the patient seen by the physician?

07 What instructions are given to the patient?

- Medication changes only or other instructions, e.g., regarding bleeding (call the office)…

Establish a Template for Clinical Staff

Follow SOAP format

Chief Complaint

Ordering practitioner

Pertinent HPI,
ROS and Exam

Confirm taking meds
as directed

Nursing education

Follow-up instructions

Communication with
ordering practitioner

How service was provided;
e.g., in-person or
interactive audio-visual

Coding Tools

DIABETES TYPE 2 (T2DM) *(not an all inclusive list, see ICD-10)*

Type 2 Diabetes without complications		Code
DM controlled and without complications	HCC 19	E11.9
DM uncontrolled w/ hyperglycemia	HCC 18	E11.65
DM uncontrolled w/ hypoglycemia, w/o coma	HCC 18	E11.649
hypoglycemia, with coma	HCC 17	E11.641
Always code for DM2 patient on insulin	HCC 19	+Z79.4
Long-term use oral hypoglycemic med *(code both when true)*		+Z79.84
DM with complication of neurological system, specifically:		
polyneuropathy	HCC 18	E11.42
mononeuropathy	HCC 18	E11.41
gastroparesis (autonomic polyneuropathy)	HCC 18	E11.43
DM with unspecified neuropathy *(avoid)*	HCC 18	E11.40
DM with neuropathic arthropathy	HCC 18	E11.610
If the DM is not in control assign *also*	HCC 18	+E11.65
Diabetes w/complication of circulatory system, specifically:		
DM with peripheral angiopathy, no gangrene	HCC 18 & 108	E11.51
DM w/peripheral angiopathy, w/ gangrene		E11.52
DM with other circulatory complication	HCC 18	E11.59
If the DM is not in control assign *also*	HCC 18	+E11.65
DM with diabetic nephropathy	HCC 18	E11.21
DM with proteinuria or microalbuminuria: E11.29 and R80.9		
DM w/complication of CKD *(code also stage CKD)*	HCC 18	E11.22
CKD stage 1 GFR >90 (Glomerular Filtration Rate)		+N18.1
CKD stage 2 GFR 60-89 (Mild)		+N18.2
CKD stage 3 unspecified (Moderate)		+N18.30
CKD stage 3a GFR 45-59 (Moderate)		+N18.31
CKD stage 3b GFR 30-44 (Moderate)		+N18.32
CKD stage 4 GFR 15-29 (Severe)	HCC 137	+N18.4
CKD stage 5 GFR <15	HCC 136	+N18.5
End Stage Renal Disease (ESRD)	HCC 136	+N18.6
If the DM is not controlled, assign also	HCC 18	+E11.65
DM with complication of eyes, specifically:		
DM w/nonproliferative retinopathy w/o edema	HCC 18	E11.329-
with macular edema	HCC 18	E11.321-
DM w/proliferative retinopathy *see choices*	HCC 18	E11.351- thru
Dash indicates must have 7th character for laterality		E11.359-
DM with diabetic cataract	HCC 18	E11.36
DM with eye complication not listed above	HCC 18	E11.39
If the DM is not in control assign *also*	HCC 18	+E11.65
Diabetes - varied complications		
DM with; arthropathy	HCC 18	E11.618
dermatitis	HCC 18	E11.620
foot ulcer *(Code also site L97.4-, L97.5-)*	HCC 18 & 161	E11.621
skin ulcer *(Code also site L97.1-L98.49)*	HCC 18 & 161	E11.622
other skin complication	HCC 18	E11.628
DM with hyperosmolarity, without coma	HCC 17	E11.00
hyperosmolarity, with coma	HCC 17	E11.01
If DM is not in control assign *also*	HCC 18	+E11.65

Signs/Symptom Codes	Code
Pre-diabetes *(borderline DM, latent DM)*	R73.03
Other visual disturbances e.g. blurry vision	H53.8
Polydipsia Excessive thirst	R63.1
Polyphasia Excessive eating/appetite	R63.2
Polyuria Frequent urination Code 1st causal condition	R35.0
Anesthesia of skin Numbness in hands/feet	R20.0
Other Polyuria	R35.8
Paresthesia of skin Tingling in hands/feet	R20.2
Abnormal Weight loss	R63.4
Miscellaneous Diagnoses	**Code**
Lab Dx: Impaired fasting glucose	R73.01
Other abnormal glucose, prediabetic	R73.09
Hyperglycemia, unspecified *(avoid)*	R73.9
Screening for diabetes mellitus *(asymptomatic)*	Z13.1
Metabolic syndrome	E88.81
Lipoid Disorders: Pure Hypercholesterolemia	E78.00
Familial hypercholesterolemia	E78.01
Hyperglyceridemia (very low density lipoid type)	E78.1
Mixed hyperlipidemia (combo of E78.0 & E78.1)	E78.2
Dislipidemia/hyperlipidemia, unspecified *(avoid)*	E78.5
Noncompliance w/treatment	Z91.19
Noncompliance w/renal dialysis	Z91.15

Also Assign Overweight/Obesity & BMI (adult)				Code
Overweight Code				**E66.3**
BMI range	25.0 - 25.9 (See peds sheet for ped BMIs)			+Z68.25
BMI range	26.0 - 26.9			+Z68.26
BMI range	27.0 - 27.9			+Z68.27
BMI range	28.0 - 28.9			+Z68.28
BMI range	29.0 - 29.9			+Z68.29
Obesity due to excess calories				**E66.09**
BMI range	30.0-30.9	268.30	BMI range 35.0-35.9	+Z68.35
BMI range	31.0-31.9	268.31	BMI range 36.0-36.9	+Z68.36
BMI range	32.0-32.9	268.32	BMI range 37.0-37.9	+Z68.37
BMI range	33.0-33.9	268.33	BMI range 38.0-38.9	+Z68.38
BMI range	34.0-34.9	268.34	BMI range 39.0-39.9	+Z68.39
Morbid Obesity due to excess calories				**E66.01**
BMI range	40.0 - 44.9			+Z68.41
BMI range	45.0 - 49.9			+Z68.42
BMI range	50.0 - 59.9			+Z68.43
BMI range	60.0 - 69.9			+Z68.44
BMI	70 or greater			+Z68.45

Status and History Codes			
Amputation, BK:	***L BK*** = 289.512	***R BK*** =	289.511
Family history of diabetes			Z83.3
Family history of familial hypercholesterolemia			Z83.42
History of tobacco dependence			Z87.891

Diabetes in pregnancy not here - see ICD10 Category O24 on pg.9

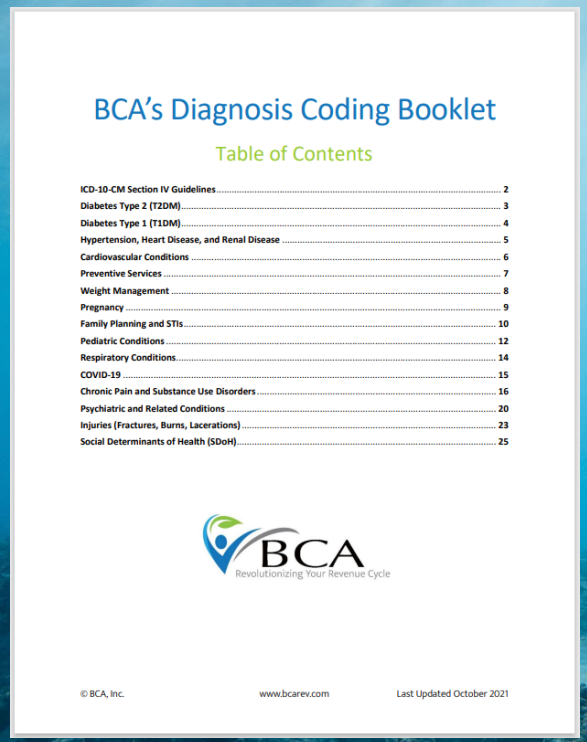
Underdosing of insulin and/or oral antidiabetic medications: T38.3X6-

7th character considerations: Replace "-" with: A = Active treatment phase, D = Healing phase, S = Sequela

Also code reason for Underdosing: Intentional d/t financial hardship Z91.120; Intentional for other reason Z91.128, Unintentional d/t age-related disability Z91.130; Unintentional d/t other reason Z91.138

ICD10 Guidelines instruct to report all conditions that require or impact care today. See pg 25 for **SDOH** impacting care: ie, homelessness

Report **Nicotine influence** with T2DM: ie, Current cigarette smoker F17.210. See page 18 for other nicotine coding options.



BCA's Diagnosis Coding Booklet

Table of Contents

ICD-10-CM Section IV Guidelines 2
Diabetes Type 2 (T2DM) 3
Diabetes Type 1 (T1DM) 4
Hypertension, Heart Disease, and Renal Disease 5
Cardiovascular Conditions 6
Preventive Services 7
Weight Management 8
Pregnancy 9
Family Planning and STIs 10
Pediatric Conditions 12
Respiratory Conditions 14
COVID-19 15
Chronic Pain and Substance Use Disorders 16
Psychiatric and Related Conditions 20
Injuries (Fractures, Burns, Lacerations) 23
Social Determinants of Health (SDoH) 25

BCA
Revolutionizing Your Revenue Cycle

 www.bcarev.com Last Updated October 2021

AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS

A quarterly publication of the Central Office on ICD-10-CM/PCS

Volume 4 First Quarter
Number 1

In This Issue

External Heart Assist Device 10
Outpatient Laboratory, Pathology and Radiology Coding 4
Screening, Surveillance, and Follow-up Colonoscopy 8

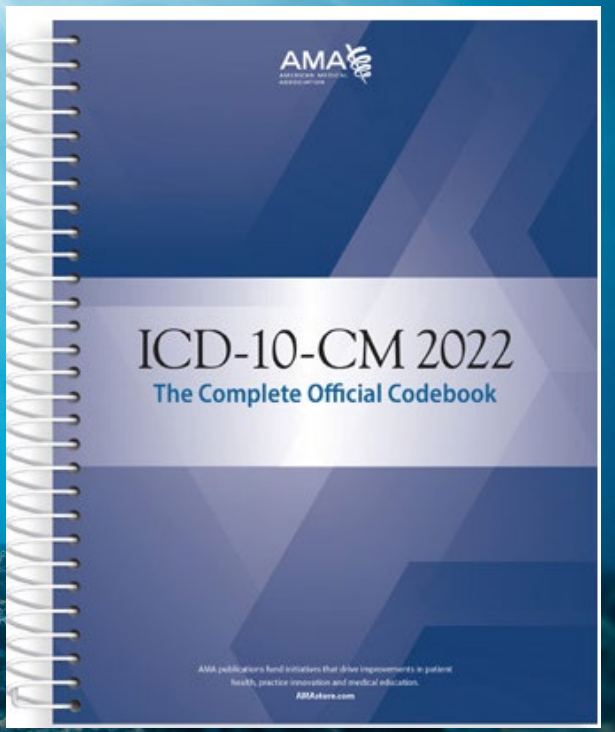
In Memoriam

Captain Robert Mullin, M.D. 53

Ask the Editor

Acute Congestive Heart Failure with Diastolic or Systolic Dysfunction 46
Acute Exacerbation of Chronic Obstructive Pulmonary Disease with Asthma 26
Alzheimer's Disease and Dementia 43
Approach Value for Mini Thoracotomy 36
Aspiration Pneumonia and Chronic Obstructive Pulmonary Disease 24
Body Mass Index 19 or Less 39
Central Catheter Placement in Femoral Vein 31
Chopart Amputation of Foot 22
Chronic Hepatitis C with Hepatic Encephalopathy 41
Chronic Obstructive Pulmonary Disease with Unspecified Asthma 25
Cyclical Vomiting Syndrome 28
Debulking of Tumor and Peritoneum Ablation 34
Dismembered Pyeloplasty 36
Dry Aspiration of Ankle Joint 50
Encounter for Native Bone Flap Placement 42
Encounter for Speech Therapy due to Autism 27
Epifix® Allograft 35
Evolving Pressuring Ulcer in the Home Care Setting 49
Exacerbation of Chronic Obstructive Pulmonary Disease and Moderate Persistent Asthma 26
Failed Lumbar Puncture 50
Gross Hematuria due to Prostate Malignancy 17
Hepatic Flexure versus Transverse Colon 16
History of Hyperplastic Polyp 14
History of Rectal Polyp 14

Coding advice or code assignments contained in this issue effective with discharges March



AMA

ICD-10-CM 2022

The Complete Official Codebook

AMA publications fund initiatives that drive improvements in patient health, practice innovation and medical education.

AMAstore.com

Five Basic Diagnosis Coding Rules

HIPAA MANDATED ICD-10 GUIDELINES – NO MATTER WHERE YOU WORK

1. The 1st listed dx identifies condition requiring the greatest work-effort as determined by the clinician and supported in the medical record.
2. Document all conditions that require/affect care.
3. Document reasons for all studies.
4. Code to the highest level of specificity known.
5. Do not use "rule out" or unconfirmed diagnoses; instead, report known signs and symptoms.

All Conditions Requiring/Impacting Care

Any conditions that may impede the healing process?

- Diabetes with circulatory or neurological manifestations?
- PVD or other vascular diseases?
- Smoking/exposure to tobacco smoke?
- Z91.19 Patient's noncompliance with other medical treatment and regimen

Any conditions that contribute to current condition?

- Z99.3 Dependence on wheelchair
- Z97.1- Presence of artificial limb (complete) (partial)
- Paralysis, hemiplegia, monoplegia, etc.

Questions?

T: 208.736.3755

www.codinghelp.com

We offer on demand training, come and see us at:
www.bcarev.com

BCA REV
Billing, Coding, Auditing, Revenue Cycle Training by BCA

General Training Disclaimer

- "CPT" is a registered trademark of the American Medical Association. Their codes, descriptions and manual content are copyright by the AMA. All rights are reserved by the AMA.
- The content of this presentation has been abbreviated for a focused presentation for a specific audience. Verify all codes and information in a current CPT book.
- This information is considered valid at the time of presentation, but changes may occur through the year.
- Information presented is not to be considered legal or medical advice.
- Third-party payment guidelines vary. Confirm payment guidelines with your payers of interest.

BCA
Revolutionizing Your Revenue Cycle

Billing, Coding, Auditing, Revenue Cycle Training by BCA