Dear Fellow CPMA Members:

I have gathered most of the information we will need to help us transition from Noridian to Trailblazer as our Medicare Intermediary. I would like to lay out a good overview of what will stay the same and what will change but I would strongly advise each of you to go to CPMA's website and access the Membership Information area and then "Transition to Trailblazer" spot and look at the various LCDs (Local Carrier Determination) policies that will affect us. If you do any Routine Foot Care, please read that entire policy. This policy specifically will be much more restrictive. Now remember, don't shoot the messenger!

TRANSITION

Our transition date from Noridian to Trailblazer is March 21, 2008. Because of the Medicare Modernization Act passed by Congress a few years ago, Colorado will be moving to a new region with new states, namely Texas, New Mexico and Oklahoma. The new region is called "J4" for Jurisdiction 4. Please go to www.trailblazerhealth.com to access all the information you will need. I have been receiving their listserves regarding the transition and you are certainly encouraged to do the same. You can sign up for listserves for both J4 transition news and one specifically for Colorado. It appears that there should be no change as far as requirements for filing claims as that is federal law.

INJECTION POLICY (See LCD "Injections, Therapeutic Local")

Our injection policy, unfortunately, will not change. Any injection for a Morton's neuroma or tibial nerve compression (Tarsal Tunnel Syndrome) will still need the unlisted foot code (28899) and the term "Morton's neuroma" or "Tarsal Tunnel Syndrome" will need to be placed in Box 19 on the CMS-1500 form or the equivalent in the electronic field. This includes both steroid injections as well as chemical neurolysis. The policy is fairly clear that any number of injections beyond 3 will be scrutinized and you will most likely need to get that approved. I am aware that sclerosing takes 4-6 injections to be potentially beneficial but a word of caution: if we start billing 4, 6, 8 or 10 injections, we could be scrutinized and they may do what Noridian did and start putting 90 day follow-ups for injections. **Please**, with Medicare, consider having the patient pay for a portion of the series of injections. I have been having these patients' sign an Advanced Beneficiary Notice and they will pay for injections that aren't covered, specifically neurolysis beyond 3 injections.

UNNA BOOTS

Trailblazer does not have a specific policy for Unna boots so it appears that these will be paid for orthopedic problems as well as for venous ulcers. There should be documentation in place that justifies the use of an Unna boot over taping, casting or bracing.

NAIL AVULSION (see LCD "Nail Avulsion")

This policy really hasn't changed. In order to do an avulsion, one must provide local anesthesia or document why not. The list of covered diagnoses is in the LCD. Treatment of symptomatic nails will be more restrictive than we have now. Noridian allows payment with the procedure codes of debridement of nails 1-5 (11720) or debridement of nails 6 or more (11721) and a diagnosis of ingrown nail (703.0) only. Not with Trailblazer; treatment of these ingrown nails will have to be either avulsion (11730 or 11732) or a matrixectomy (11750). An E&M visit can only be justified initially, if you are doing an examination, discussing causes, treatment options, etc. If you just do a slant-back or other more simple treatment on that order, it is not covered. Trailblazers will want to see the T- modifiers with toe surgery.

TREATMENT of SYMPTOMATIC LESIONS

Debriding a PAINFUL callus (11050 series) with a diagnosis of corns or calluses (700) and a secondary diagnosis of pain in limb (729.5) **will not** be paid with Trailblazer. If the patient does not meet the systemic problem requirements to qualify for routine foot care, this would not be covered. Initially, if you go over the condition, causes, treatment options, etc, that may be an E&M due to face-to-face counseling, but after that, it would not be covered. If you treat these with chemosurgery (17110) or excision (11420 series), see "Removal of Benign and Malignant Skin Lesions" below.

ROUTINE FOOT CARE (See LCD "Routine Foot Care/Mycotic Nail Debridement")

This is the policy that is the most complex and unfortunately, most of us need to know. With Noridian, we were able to debride nails on covered patients and the nail code could be either 110.1 (mycotic nails) or 703.8 (dystrophic or deformed nails). With Trailblazer, the only nail code that can be used is 110.1 (mycotic nails), not dystrophic nails (703.8). They have a somewhat loose definition of mycosis: hypertrophic/thickened, brittle, loosening, discolored and/or lysis. We must use our discretion on this according to our new medical director, Dr. Debra Patterson. I would not recommend pushing this envelope too far. The definition of debridement (11720 or 11721) is also going to change. With Noridian, reduction of the nails was enough but with Trailblazer, their definition is reduction of thickness and length. If the only care of the nail is shortening and not thinning or getting to the attachment of the nail, this would be trimming of the nail (11719). It appears that there will be no change in the systemic disease requirements, these are federal law. Personally, I will be contacting many of my patients that used to be covered for RFC to let them know that they will no longer be covered.

As far as Q modifiers go, Trailblazers does not yet understand that the Q modifiers do not work with all of the non-vascular systemic conditions. I had this problem with Noridian and had to go through the Medicare Regional office on Denver to get this straightened

out. For example, if a patient has peripheral neuropathy, they would not fit into the Q modifier scenarios but they still should be covered. Dr. Patterson had been made aware of this inconsistency and that I will pursue this issue if it is not resolved. She has told me that her staff is working on how to code these patients.

One may continue to be paid for mycotic nail treatment without systemic problems with the primary diagnosis of mycosis (110.1) and a secondary diagnosis of; cellulits/abcess (681.10-681.11), ingrowing nail (703.0), difficulty in walking (719.7) or pain from the mycotic nail (729.5). Be sure to DOCUMENT these conditions. Also, these need to be treated "definitively", which means that a prescription for a topical or oral anti-fungal MUST be given or they are not covered. If a prescription is not given there must be a reason in the record.

LOPS: The LOPS (Loss of Protective Sensation) Policy has not changed.

Documentation: Also, the documentation needed for RFC is going to change. Periodically, we need to document the appearance of EVERY nail to meet Trailblazer's documentation requirements (I have developed a check form for each nail for my office). A portion of Trailblazer's documentation requirements contain the following statements:

- "For foot care services covered by virtue of the presence of a qualifying covered systemic disease, Medicare expects the clinical record to contain a sufficiently detailed clinical description of the feet to provide convincing evidence that nonprofessional performance of the service is hazardous to the patient. For this purpose, documentation limited to a simple listing of class findings is insufficient. Medicare does not require the detailed clinical description to be repeated at each instance of routine foot care when an earlier record continues to accurately describe the patient's condition at the time of the foot care. In such cases, the record should reference the location in the record of the previously recorded detailed information."
- "For coverage of mycotic nail debridement by reason of the presence of specified conditions (i.e., in the absence of a qualifying covered systemic disease), the record should contain a description of the specified condition beyond a mere mention that the particular condition is present (i.e., painful nails, limited ambulation, infection)."
- "For debridement of multiple asymptomatic mycotic nails in people who have a qualifying systemic condition, the record should demonstrate the necessity of debridement of each debrided nail considering the patient's usual activities." This will be somewhat difficult to document, in my opinion.
- "Clinical rationale for treatment of mycotic nails with less than definitive care (i.e., debridement without pharmacological intervention) should be explained in the record."

- "Debridement of nails, whether by electric grinder or manual method, is a temporary reduction in the length and thickness (short of avulsion) of an abnormal nail plate. This is usually performed without anesthesia. The debridement code should not be used if the only part of the nail removed is the distal nail border or other portion of nail not attached to the nail bed."

So, bottom line, if you are only reducing the length of a nail, this cannot be billed as a debridement, it must be billed as a trim. Also, if the nails are not mycotic, they are NOT covered. Again, I strongly urge you to read the entire Routine Foot Care LCD Policy on CPMA's website under "Transition to Trailblazer" for all of the nuances of language, documentation requirements and coverage.

WOUND CARE (see LCD "Wound Care")

This policy also has not changed much. The documentation requirements are rather stringent and I would strongly recommend you follow them well. I feel this is an area that has potential to be looked at a lot by the Medicare intermediaries. The documentation includes: how debrided, nature of the wound, its appearance both before and after debridement, what was debrided, etc. Please read the whole LCD.

SKIN SUBSTITUTE (see LCD "Skin Substitutes")

Trailblazer is adopting Colorado's policy. I will admit this is an area I am not totally "up" on, so I would again recommend reading the LCD on this topic.

VASCULAR STUDIES (see LCD "Non-Invasive Peripheral Arterial Studies")

It appears that only vascular technicians may bill for non-invasive vascular exams.

REMOVAL OF BENIGN AND MALIGNANT SKIN LESIONS (See LCD "Removal of Benign and Malignant Skin Lesions")

Noridian allowed us to bill the cutting callus/corn code (11055 series) with a secondary diagnosis code of pain. Trailblazer's policy does not address painful calluses, so debriding a painful callus will not be covered. Covered diagnoses for chemosurgery (17110) or excision (11040 series) is fairly limited for us, namely warts that are painful or show evidence of inflammation. Keratodermas (701.1) and porokeratoses (757.39) are not specifically listed in the covered diagnoses but the generic benign skin lesion code (216.7) is. I guess I would assume that skin lesions other than warts are not covered. To be covered, the lesions must have pain, intense itching, bleeding, suspicious behavior

and/or signs of inflammation (redness, oozing, purulence, edema, etc.). Again, document these findings.

SUMMARY

I was hoping for a little more liberal interpretation of existing policies for our transition to Trailblazer but they had to take all of the existing LCDs from Texas, New Mexico, Oklahoma and Colorado for all specialties and combine them into 1 LCD for each policy. All CAC activities were suspended during this consolidation process so CAC members had no input. I guess it's a bit of consolation that Texas, New Mexico and Oklahoma will now be stuck with our injection policy and they are not happy about it. Hey, welcome to OUR world! So, once the transition has occurred and the CAC process is reinstituted, we will see what we can get back. I will try to get out more information that you may need as it comes to me. Again, access www.trailblazerhealth.com for more information than you care to have. Please call me if you have any questions or need further clarification on any of this.

Good luck to us all!

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