

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

podiatry cms

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Podiatry Services Billing Examples: CMS-1500

Examples in this section are to assist providers in billing for podiatry services on the *CMS-1500* claim form. Refer to the *Podiatry Services* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Surgical Procedure
and Supplies**

Figure 1. Podiatrist Billing for a Surgical Procedure and Supplies.

This is a sample only. Please adapt to your billing situation.

Surgical procedures and supplies require authorization. In this example, a podiatrist treated onychia and paronychia of the toe by excision of nail in his office. The *Treatment Authorization Request* (TAR) number is entered in the *Prior Authorization Number* field (Box 23).

CPT-4 code 11730 (avulsion of nail plate, partial or complete, simple; single) is billed with modifier AG (indicating the procedure was performed by the primary surgeon) on claim line one. On claim line 2 the same code is billed with modifier UA (supplies and drugs for surgical procedures without general anesthesia). These codes are entered in the *Procedures, Services or Supplies* field (Box 24D).

An appropriate ICD-9-CM diagnosis code is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). In this example, ICD-9-CM code 681.11 represents onychia and paronychia of the toe.

In this example, information describing the procedures performed and the supplies used is entered in the *Reserved for Local Use* field (Box 19). This information is optional but is recommended because it helps claim examiners price the supplies being billed.

Enter the date of the injury that resulted in the need for the toe excision in the *Date of Current Illness, Injury or Pregnancy (LMP)* field (Box 14). This information is optional but facilitates claim processing.

In the *Date(s) of Service* field (Box 24A), enter the office visit date November 4, 2010 on both claim lines 1 and 2 as 110410. Enter Place of Service code 11 (office) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F). Enter a 1 in the *Days or Units* field (Box 24G) for each claim line.

<p>1500</p> <p>HEALTH INSURANCE CLAIM FORM</p> <p>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																	
<p>1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/></p> <p>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</p>																	
<p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>DOE JOHN</p>						<p>3. PATIENT'S BIRTH DATE</p> <p>MM DD YY 06 21 62</p>			<p>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>9000000A95001</p>								
<p>5. PATIENT'S ADDRESS (No., Street)</p> <p>1234 MAIN STREET</p>						<p>6. PATIENT RELATIONSHIP TO INSURED</p> <p>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>7. INSURED'S ADDRESS (No., Street)</p>								
<p>CITY</p> <p>ANYTOWN</p>				<p>STATE</p> <p>CA</p>		<p>8. PATIENT STATUS</p> <p>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></p>			<p>CITY</p>								
<p>ZIP CODE</p> <p>95823</p>		<p>TELEPHONE (Include Area Code)</p> <p>(916) 555-5555</p>				<p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p>			<p>10. IS PATIENT'S CONDITION RELATED TO:</p>								
<p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p>						<p>a. EMPLOYMENT? (Current or Previous)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>a. INSURED'S DATE OF BIRTH</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>								
<p>b. OTHER INSURED'S DATE OF BIRTH</p> <p>MM DD YY M <input type="checkbox"/> F <input type="checkbox"/></p>						<p>b. AUTO ACCIDENT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)</p>			<p>b. EMPLOYER'S NAME OR SCHOOL NAME</p>								
<p>c. EMPLOYER'S NAME OR SCHOOL NAME</p>						<p>c. OTHER ACCIDENT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>			<p>c. INSURANCE PLAN NAME OR PROGRAM NAME</p>								
<p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p>						<p>10d. RESERVED FOR LOCAL USE</p>			<p>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i></p>								
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p>																	
<p>SIGNED _____ DATE _____</p>						<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNED _____</p>											
<p>14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</p> <p>MM DD YY 11 04 10</p>				<p>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</p> <p>MM DD YY</p>				<p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</p> <p>FROM MM DD YY TO MM DD YY</p>									
<p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</p>						<p>17a. _____</p>			<p>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</p> <p>FROM MM DD YY TO MM DD YY</p>								
<p>17b. NPI _____</p>						<p>19. RESERVED FOR LOCAL USE</p> <p>COMPLETE EXCISION OF TOENAIL/SURGICAL TRAY</p>											
<p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</p> <p>1. 68111</p>						<p>22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>23. PRIOR AUTHORIZATION NUMBER</p> <p>01234567890</p>											
<p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</p> <p>B. PLACE OF SERVICE</p> <p>C. EMG</p> <p>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MODIFIER</p> <p>E. DIAGNOSIS POINTER</p>						<p>F. \$ CHARGES</p>		<p>G. DRY'S OR UNITS</p>		<p>H. EPDOT Family Plan</p>		<p>I. ID. QUAL.</p>		<p>J. RENDERING PROVIDER ID. #</p>			
<p>1 11 04 10 11 11730 AG</p>						<p>19500</p>		<p>1</p>		<p>NPI</p>							
<p>2 11 04 10 11 11730 UA</p>						<p>3000</p>		<p>1</p>		<p>NPI</p>							
<p>3</p>										<p>NPI</p>							
<p>4</p>										<p>NPI</p>							
<p>5</p>										<p>NPI</p>							
<p>6</p>										<p>NPI</p>							
<p>25. FEDERAL TAX I.D. NUMBER</p>				<p>SSN EIN</p>		<p>26. PATIENT'S ACCOUNT NO.</p>		<p>27. ACCEPT ASSIGNMENT? (For gov't. claims, see back)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>28. TOTAL CHARGE</p> <p>\$ 22500</p>		<p>29. AMOUNT PAID</p> <p>\$</p>		<p>30. BALANCE DUE</p> <p>\$ 22500</p>			
<p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</p> <p><i>Jane Doe</i></p> <p>SIGNED _____ DATE 11/30/10</p>						<p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>a. NPI b. _____</p>						<p>33. BILLING PROVIDER INFO & PH # (916) 555-5555</p> <p>JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555</p> <p>a. 0123456789 b. _____</p>					
<p>NUCC Instruction Manual available at: www.nucc.org</p>																	
<p>APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)</p>																	

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