Optum

Coding Companion

# Podiatry

A comprehensive illustrated guide to coding and reimbursement



2024

optumcoding.com

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# Getting Started with Coding Companion

*Coding Companion for Podiatry* is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

## CPT/HCPCS Codes

For ease of use, evaluation and management codes related to podiatry are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

### *Resequencing of CPT Codes*

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

## ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

## Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

## Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

## CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

## Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

28285 Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)

could be found in the index under the following main terms:

**Foot**
Hammertoe Operation, 28285

*or* **Hammertoe Repair** 28285-28286

*or* **Reconstruction**
Toe
Hammertoe, 28285-28286

## General Guidelines

### *Providers*

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

### *Supplies*

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

### *Professional and Technical Component*

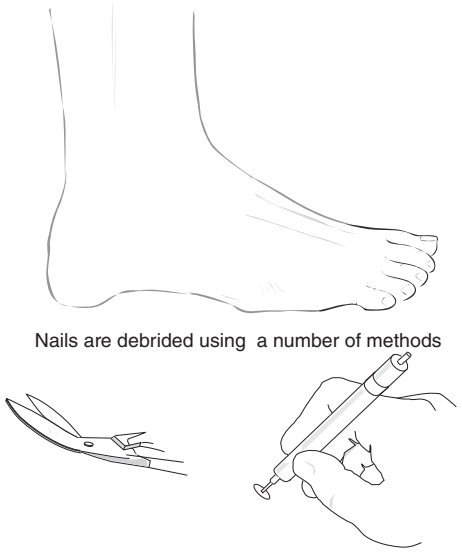
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

## Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

# 11720-11721

**11720** Debridement of nail(s) by any method(s); 1 to 5
**11721** 6 or more




## Explanation

The physician debrides toenails, including tops and exposed undersides, by any method. The cleaning is performed manually with cleaning solutions, abrasive materials, and tools. The nails are shortened and shaped. Report 11720 for one to five nails and 11721 for six or more.

## Coding Tips

These codes are reported only once regardless of the number of nails that are trimmed. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. For trimming of nondystrophic nails, see 11719. For the trimming of dystrophic nails, see G0127.

## ICD-10-CM Diagnostic Codes

B35.1 Tinea unguium
B37.2 Candidiasis of skin and nail
L03.031 Cellulitis of right toe ☑
L03.032 Cellulitis of left toe ☑
L60.0 Ingrowing nail
L60.1 Onycholysis
L60.2 Onychogryphosis
L60.3 Nail dystrophy
L60.8 Other nail disorders
Q84.6 Other congenital malformations of nails

## Associated HCPCS Codes

G0127 Trimming of dystrophic nails, any number
G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails
S0390 Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit

**AMA:** **11720** 2022,Feb; 2021,Aug **11721** 2022,Feb; 2021,Aug

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **11720** | 0.32 | 0.6 | 0.04 | 0.96 |
| **11721** | 0.54 | 0.72 | 0.04 | 1.3 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **11720** | 0.32 | 0.07 | 0.04 | 0.43 |
| **11721** | 0.54 | 0.12 | 0.04 | 0.7 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **11720** | 0 | A | 1(2) | N/A | N/A | N/A | N/A | 100-03,70.2.1 |
| **11721** | 0 | A | 1(2) | N/A | N/A | N/A | N/A | |

* with documentation

## Terms To Know

**cellulitis.** Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

**congenital.** Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

**LOPS.** Loss of protective sensation. Reduction in anatomic nerve function so the patient cannot sense minor trauma from heat, chemicals, or mechanical sources. This disorder is usually associated with the foot, and secondary to another disorder like diabetes or amyloidosis.

**neuropathy.** Abnormality, disease, or malfunction of the nerves.

## 1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2023.

The following icons are used in *Coding Companion:*

● This CPT code is new for 2023.

▲ This CPT code description is revised for 2023.

✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

| | | | | | | |
|---|---|---|---|---|---|---|
| 90785 | 90791 | 90792 | 90832 | 90833 | 90834 | 90836 |
| 90837 | 90838 | 90839 | 90840 | 90845 | 90846 | 90847 |
| 92507 | 92508 | 92521 | 92522 | 92523 | 92524 | 96040 |
| 96110 | 96116 | 96160 | 96161 | 97802 | 97803 | 97804 |
| 99406 | 99407 | 99408 | 99409 | 99497 | 9949 | |

## 2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

## 3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

## 4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

## 5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- **N** Newborn: 0
- **P** Pediatric: 0-17
- **M** Maternity: 9-64
- **A** Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

## 6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

## 7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

## 8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

### *Relative Value Units*

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

# Evaluation and Management (E/M) Services Guidelines

## E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

## Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

### *New and Established Patients*

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

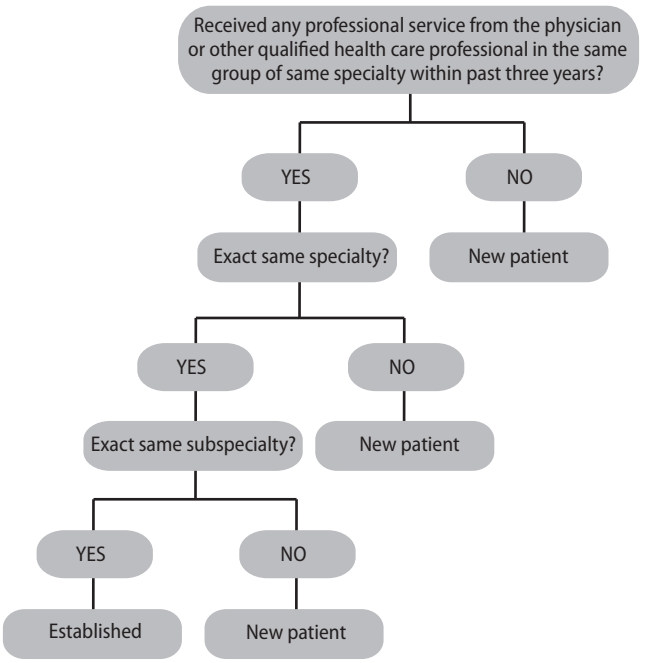
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

***Decision Tree for New vs Established Patients***








▶ ◀ = Contains new or revised text

# 99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

## Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

## Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

## ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

**AMA:** **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **99202** | 0.93 | 1.12 | 0.09 | 2.14 |
| **99203** | 1.6 | 1.52 | 0.17 | 3.29 |
| **99204** | 2.6 | 2.06 | 0.24 | 4.9 |
| **99205** | 3.5 | 2.66 | 0.32 | 6.48 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **99202** | 0.93 | 0.41 | 0.09 | 1.43 |
| **99203** | 1.6 | 0.67 | 0.17 | 2.44 |
| **99204** | 2.6 | 1.11 | 0.24 | 3.95 |
| **99205** | 3.5 | 1.54 | 0.32 | 5.36 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **99202** | N/A | A | 1(2) | N/A | N/A | N/A | 80* | None |
| **99203** | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |
| **99204** | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |
| **99205** | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |

* with documentation

## Terms To Know

**face to face.** Interaction between two parties, usually provider and patient, that occurs in the physical presence of each other.

**new patient.** Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

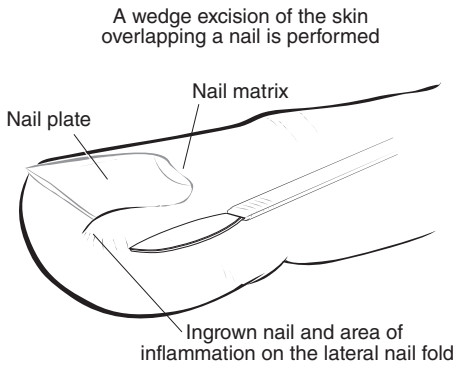




 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality 

# 11765

**11765** Wedge excision of skin of nail fold (eg, for ingrown toenail)




## Explanation

The physician excises a wedge of restrictive skin in the nail fold to free an ingrown nail. The physician performs a wedge excision of the skin overlapping the lateral nail. The nail is examined and trimmed to encourage straight growth. The wound is dressed.

## Coding Tips

Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. Some payers may require the use of HCPCS Level II modifiers TA–T9 to identify the specific toe involved. If a specimen is transported to an outside laboratory, report 99000–99001 for handling or conveyance. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For excision of a nail and nail matrix, partial or complete, for permanent removal, see 11750. For avulsion of a nail plate, see 11730–11732.

## ICD-10-CM Diagnostic Codes

L03.031 Cellulitis of right toe ☑
L03.032 Cellulitis of left toe ☑
L60.0 Ingrowing nail

**AMA:** **11765** 2022,Feb; 2021,Aug

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **11765** | 1.22 | 3.63 | 0.1 | 4.95 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **11765** | 1.22 | 1.37 | 0.1 | 2.69 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **11765** | 10 | A | 4(3) | 51 | N/A | N/A | N/A | None |

* with documentation

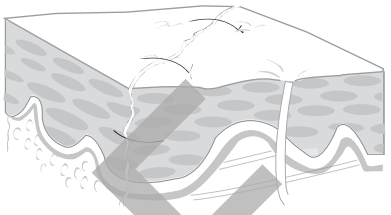
## Terms To Know

**onychia.** Inflammation or infection of the nail matrix leading to a loss of the nail.

**wedge excision.** Surgical removal of a section of tissue that is thick at one edge and tapers to a thin edge.

# 12001-12007

**12001** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
**12002** 2.6 cm to 7.5 cm
**12004** 7.6 cm to 12.5 cm
**12005** 12.6 cm to 20.0 cm
**12006** 20.1 cm to 30.0 cm
**12007** over 30.0 cm



Example of a simple closure involving only one skin layer, the epidermis

## Explanation

The physician performs wound closure of superficial lacerations of the extremities using sutures, staples, tissue adhesives, or a combination of these materials. A local anesthetic is injected around the wound and it is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues. For multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12001 for a total length of 2.5 cm or less; 12002 for 2.6 cm to 7.5 cm; 12004 for 7.6 cm to 12.5 cm; 12005 for 12.6 cm to 20 cm; 12006 for 20.1 cm to 30 cm; and 12007 if the total length is greater than 30 cm.

## Coding Tips

When multiple wounds are repaired, add together the lengths of those in the same classification and report as a single item. Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. Single-layer closure of a wound requiring extensive cleaning or removal of contaminated foreign matter or damaged tissue is classified as an intermediate repair. Wound closures by adhesive strips alone should not be reported with repair codes; instead, report the appropriate E/M service code. Local anesthesia is included in these services. Suture removal is included in these procedures. It is inappropriate to report supplies when these services are performed in an emergency room. For wound care closure by tissue adhesive(s) only, see HCPCS Level II code G0168.

## ICD-10-CM Diagnostic Codes

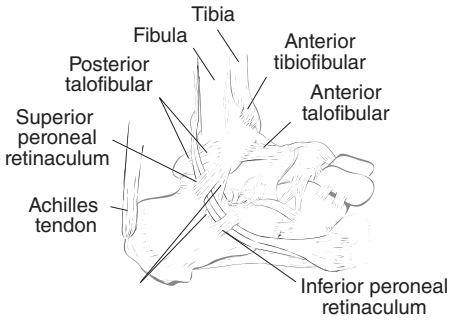
S91.011A Laceration without foreign body, right ankle, initial encounter ☑
S91.051A Open bite, right ankle, initial encounter ☑
S91.111A Laceration without foreign body of right great toe without damage to nail, initial encounter ☑
S91.114A Laceration without foreign body of right lesser toe(s) without damage to nail, initial encounter ☑
S91.151A Open bite of right great toe without damage to nail, initial encounter ☑
S91.154A Open bite of right lesser toe(s) without damage to nail, initial encounter ☑
S91.211A Laceration without foreign body of right great toe with damage to nail, initial encounter ☑



 **N** Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only 

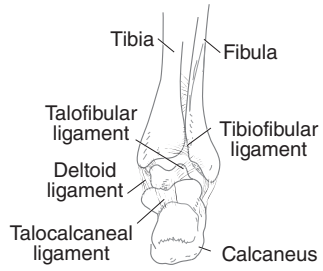
# 27620

**27620** Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body




The ankle joint is surgically explored. Loose or foreign bodies may be removed and biopsy samples collected

Lateral and posterior views of right ankle




Achilles tendon not shown

## Explanation

The physician performs an arthrotomy of the ankle that includes exploration, drainage, or removal of any foreign body. An incision is made over the ankle area to be exposed. The soft tissues are dissected away and the joint capsule is exposed and incised. The joint space is explored, any necrotic tissue is removed, and infection or abnormal fluid is drained. If a foreign body is present (e.g., bullet, nail, gravel), it is exposed and removed. The wound is irrigated with antibiotic solution. The physician may leave the wound packed open with daily dressing changes to allow for further drainage or secondary healing by granulation. If the incision is repaired, drain tubes may be inserted and the incision is closed in multiple layers with sutures, staples, and/or Steri-strips.

## Coding Tips

This procedure includes joint exploration. To report arthrotomy for incision and drainage or simple removal of a foreign body, see 27610. For arthroscopic removal of a foreign body, see 29894.

## ICD-10-CM Diagnostic Codes

M05.471 Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot ☑

M05.472 Rheumatoid myopathy with rheumatoid arthritis of left ankle and foot ☑

M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot ☑

M05.572 Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot ☑

M05.771 Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement ☑

M05.772 Rheumatoid arthritis with rheumatoid factor of left ankle and foot without organ or systems involvement ☑

M05.871 Other rheumatoid arthritis with rheumatoid factor of right ankle and foot ☑

M05.872 Other rheumatoid arthritis with rheumatoid factor of left ankle and foot ☑

M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot ☑

M06.072 Rheumatoid arthritis without rheumatoid factor, left ankle and foot ☑

M06.871 Other specified rheumatoid arthritis, right ankle and foot ☑

M06.872 Other specified rheumatoid arthritis, left ankle and foot ☑

M12.571 Traumatic arthropathy, right ankle and foot ☑

M12.572 Traumatic arthropathy, left ankle and foot ☑

M19.071 Primary osteoarthritis, right ankle and foot ☑

M19.072 Primary osteoarthritis, left ankle and foot ☑

M19.171 Post-traumatic osteoarthritis, right ankle and foot ☑

M19.172 Post-traumatic osteoarthritis, left ankle and foot ☑

M19.271 Secondary osteoarthritis, right ankle and foot ☑

M19.272 Secondary osteoarthritis, left ankle and foot ☑

M24.071 Loose body in right ankle ☑

M24.072 Loose body in left ankle ☑

M24.871 Other specific joint derangements of right ankle, not elsewhere classified ☑

M24.872 Other specific joint derangements of left ankle, not elsewhere classified ☑

M25.571 Pain in right ankle and joints of right foot ☑

M25.572 Pain in left ankle and joints of left foot ☑

M93.271 Osteochondritis dissecans, right ankle and joints of right foot ☑

M93.272 Osteochondritis dissecans, left ankle and joints of left foot ☑

S91.021A Laceration with foreign body, right ankle, initial encounter ☑

S91.022A Laceration with foreign body, left ankle, initial encounter ☑

S91.041A Puncture wound with foreign body, right ankle, initial encounter ☑

S91.042A Puncture wound with foreign body, left ankle, initial encounter ☑

**AMA:** **27620** 2022,Oct

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **27620** | 6.15 | 6.25 | 0.98 | 13.38 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **27620** | 6.15 | 6.25 | 0.98 | 13.38 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **27620** | 90 | A | 1(2) | 51 | 50 | 62* | 80 | None |

* with documentation

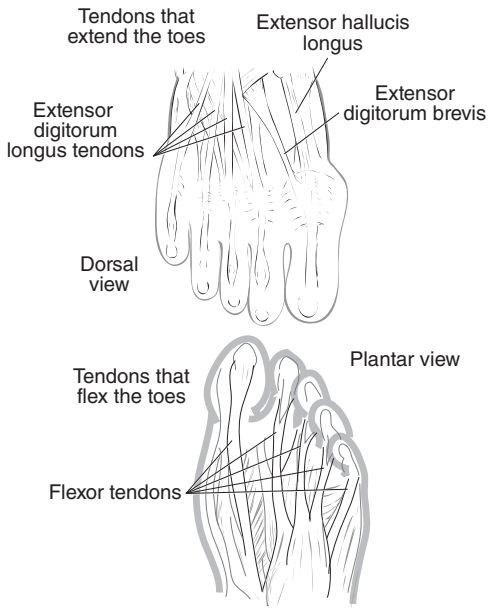
## Terms To Know

**arthrotomy.** Surgical incision into a joint that may include exploration, drainage, or removal of a foreign body.

**foreign body.** Any object or substance found in an organ and tissue that does not belong under normal circumstances.

# 28010-28011

**28010** Tenotomy, percutaneous, toe; single tendon
**28011** multiple tendons




A percutaneous tenotomy is performed on a toe

## Explanation

This procedure is performed to correct mallet or hammer toe. The physician makes a small incision at the crease of the toe where the tendon is restricted. The tendon is released from the bone and the toe is straightened. The incision is sutured and dressing applied. Report 28011 if more than one tendon is being straightened.

## Coding Tips

For open tenotomy, see 28230–28234.

## ICD-10-CM Diagnostic Codes

M20.11 Hallux valgus (acquired), right foot ☑
M20.12 Hallux valgus (acquired), left foot ☑
M20.21 Hallux rigidus, right foot ☑
M20.22 Hallux rigidus, left foot ☑
M20.31 Hallux varus (acquired), right foot ☑
M20.32 Hallux varus (acquired), left foot ☑
M20.41 Other hammer toe(s) (acquired), right foot ☑
M20.42 Other hammer toe(s) (acquired), left foot ☑
M20.5X1 Other deformities of toe(s) (acquired), right foot ☑
M20.5X2 Other deformities of toe(s) (acquired), left foot ☑
M21.611 Bunion of right foot ☑
M21.612 Bunion of left foot ☑
M21.621 Bunionette of right foot ☑
M21.622 Bunionette of left foot ☑
Q66.89 Other specified congenital deformities of feet

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **28010** | 2.97 | 3.63 | 0.25 | 6.85 |
| **28011** | 4.28 | 4.57 | 0.4 | 9.25 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **28010** | 2.97 | 2.86 | 0.25 | 6.08 |
| **28011** | 4.28 | 3.53 | 0.4 | 8.21 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **28010** | 90 | A | 4(3) | 51 | N/A | N/A | N/A | None |
| **28011** | 90 | A | 4(3) | 51 | N/A | N/A | N/A | |

* with documentation

## Terms To Know

**hallux malleus.** Deformity in which there is hammertoe of the great toe.

**hallux rigidus.** Deformity in which there is severe flexion of the great toe causing pain and limited movement.

**hallux valgus.** Deformity in which the great toe deviates toward the other toes and may even be positioned over or under the second toe.

**hallux varus.** Deformity in which the great toe deviates away from the other toes.

**suture.** Numerous stitching techniques employed in wound closure.

***buried suture.*** Continuous or interrupted suture placed under the skin for a layered closure.

***continuous suture.*** Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

***interrupted suture.*** Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

***purse-string suture.*** Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

***retention suture.*** Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

**tenotomy.** Cutting into a tendon.

# 29345-29355

**29345** Application of long leg cast (thigh to toes);
**29355** walker or ambulatory type

## Explanation

The physician applies a cast from the thigh to the toes. The physician places the ankle and knee at the desired angle. Cast padding is applied from the toes to the upper portion of the thigh. Casting material is moistened and applied in an overlapping pattern from the toes to the upper thigh and allowed to harden. Report 29355 if the cast is a walker or ambulatory type.

## Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately.

## ICD-10-CM Diagnostic Codes

M84.361A Stress fracture, right tibia, initial encounter for fracture ☑
M84.363A Stress fracture, right fibula, initial encounter for fracture ☑
M84.461A Pathological fracture, right tibia, initial encounter for fracture ☑
M84.463A Pathological fracture, right fibula, initial encounter for fracture ☑
M84.561A Pathological fracture in neoplastic disease, right tibia, initial encounter for fracture ☑
M84.563A Pathological fracture in neoplastic disease, right fibula, initial encounter for fracture ☑

**AMA:** **29345** 2022,May; 2018,Jan **29355** 2022,May; 2018,Jan

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **29345** | 1.4 | 2.3 | 0.27 | 3.97 |
| **29355** | 1.53 | 2.34 | 0.29 | 4.16 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **29345** | 1.4 | 1.25 | 0.27 | 2.92 |
| **29355** | 1.53 | 1.3 | 0.29 | 3.12 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **29345** | 0 | A | 1(3) | 51 | 50 | N/A | N/A | None |
| **29355** | 0 | A | 1(3) | 51 | 50 | N/A | N/A | |

* with documentation

# 29405-29425

**29405** Application of short leg cast (below knee to toes);
**29425** walking or ambulatory type

## Explanation

The physician applies a cast below the knee to the toes. The physician positions the ankle at the desired angle. Cast padding is applied from the toes to just below the knees. Casting material is moistened and applied to the leg in an overlapping fashion and allowed to dry. Report 29425 if the cast is a walking or ambulatory type.

## Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately.

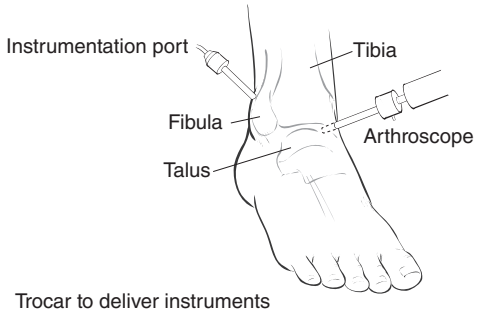
## ICD-10-CM Diagnostic Codes

M24.471 Recurrent dislocation, right ankle ☑
M24.474 Recurrent dislocation, right foot ☑
M24.571 Contracture, right ankle ☑
M24.574 Contracture, right foot ☑
M80.061A Age-related osteoporosis with current pathological fracture, right lower leg, initial encounter for fracture A ☑
M80.071A Age-related osteoporosis with current pathological fracture, right ankle and foot, initial encounter for fracture A ☑
M84.361A Stress fracture, right tibia, initial encounter for fracture ☑
M84.363A Stress fracture, right fibula, initial encounter for fracture ☑
M84.371A Stress fracture, right ankle, initial encounter for fracture ☑
M84.374A Stress fracture, right foot, initial encounter for fracture ☑
M84.471A Pathological fracture, right ankle, initial encounter for fracture ☑
M84.474A Pathological fracture, right foot, initial encounter for fracture ☑
M84.571A Pathological fracture in neoplastic disease, right ankle, initial encounter for fracture ☑
M84.574A Pathological fracture in neoplastic disease, right foot, initial encounter for fracture ☑
M92.61 Juvenile osteochondrosis of tarsus, right ankle ☑
M92.71 Juvenile osteochondrosis of metatarsus, right foot ☑
S82.221A Displaced transverse fracture of shaft of right tibia, initial encounter for closed fracture ☑
S82.311A Torus fracture of lower end of right tibia, initial encounter for closed fracture ☑
S82.421A Displaced transverse fracture of shaft of right fibula, initial encounter for closed fracture ☑
S82.51XA Displaced fracture of medial malleolus of right tibia, initial encounter for closed fracture ☑
S82.61XA Displaced fracture of lateral malleolus of right fibula, initial encounter for closed fracture ☑
S92.211A Displaced fracture of cuboid bone of right foot, initial encounter for closed fracture ☑
S92.211B Displaced fracture of cuboid bone of right foot, initial encounter for open fracture ☑

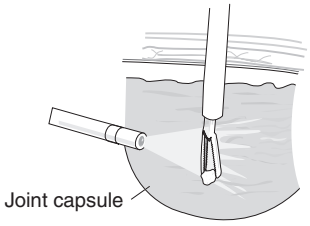
# 29897-29898

**29897** Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited

**29898** debridement, extensive




Trocar to deliver instruments




Schematic of removal of debris from capsule

## Explanation

The physician performs arthroscopy on the ankle joint to minimally debride the joint. With the patient under general anesthesia, the physician makes two to four 0.5 cm skin incisions around the ankle joint. The arthroscope is introduced into the ankle joint, and an examination is performed. The physician identifies areas of the joint where debridement is required. Additional surgical instruments are placed through the skin portals and into the joint. These are used to debride frayed, nonviable, or extraneous tissue. In 29898, a more extensive debridement is performed. The ankle is irrigated, and the skin incisions are closed. A dressing is applied.

## Coding Tips

Surgical arthroscopy includes a diagnostic arthroscopy. CPT guidelines indicate that when the physician cannot complete the procedure through the arthroscope and an open procedure is performed, list the open procedure first, code the arthroscope as diagnostic, and append modifier 51. Medicare and some other third-party payers do not allow a scope procedure when performed in conjunction with a related open procedure. Check with individual payers regarding their specific coding guidelines. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For a radiology exam of the ankle, see 73600–73615.

## ICD-10-CM Diagnostic Codes

M05.471 Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot ☑

M06.071 Rheumatoid arthritis without rheumatoid factor, right ankle and foot ☑

M06.271 Rheumatoid bursitis, right ankle and foot ☑

M06.371 Rheumatoid nodule, right ankle and foot ☑

M07.671 Enteropathic arthropathies, right ankle and foot ☑

M93.271 Osteochondritis dissecans, right ankle and joints of right foot ☑

M94.271 Chondromalacia, right ankle and joints of right foot ☑

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **29897** | 7.32 | 6.16 | 1.11 | 14.59 |
| **29898** | 8.49 | 6.88 | 1.26 | 16.63 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **29897** | 7.32 | 6.16 | 1.11 | 14.59 |
| **29898** | 8.49 | 6.88 | 1.26 | 16.63 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **29897** | 90 | A | 1(2) | 51 | 50 | N/A | 80 | None |
| **29898** | 90 | A | 1(2) | 51 | 50 | 62* | 80 | |

* with documentation

## Terms To Know

**chondromalacia.** Condition in which the articular cartilage softens, seen in various body sites but most often in the patella, and may be congenital or acquired.

**debridement.** Removal of dead or contaminated tissue and foreign matter from a wound.

**osteoarthrosis.** Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.

**polyneuropathy.** Disease process of severe inflammation of multiple nerves.

# G0247

**G0247** Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

## Explanation

Routine foot care is provided by a physician to a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation and must include, when present, all of the following: local care of superficial wounds, debridement of corns and calluses, and trimming and debridement of nails.

## Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. Modifier Q7, Q8, or Q9 should be appended to indicate a significant systemic condition (e.g., diabetes mellitus, peripheral neuropathies involving the feet) that puts the patient at risk for problems with wound healing and potential loss of limb. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

## ICD-10-CM Diagnostic Codes

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy

E10.44 Type 1 diabetes mellitus with diabetic amyotrophy

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

E11.44 Type 2 diabetes mellitus with diabetic amyotrophy

E13.44 Other specified diabetes mellitus with diabetic amyotrophy

E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| G0247 | 0.5 | 1.97 | 0.02 | 2.49 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| G0247 | 0.5 | 0.11 | 0.02 | 0.63 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| G0247 | N/A | R | 1(2) | N/A | N/A | N/A | 80* | None |

* with documentation

## Terms To Know

**atherosclerosis.** Buildup of yellowish plaques composed of cholesterol and lipoid material within the arteries.

**diabetes mellitus.** Endocrine disease manifested by high blood glucose levels and resulting in the inability to successfully metabolize carbohydrates, proteins, and fats, due to defects in insulin production and secretion, insulin action, or both.

# G0281-G0283

**G0281** Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

**G0282** Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

**G0283** Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

## Explanation

Electrical stimulation is the use of electric current that mimics the body's own natural bioelectric system's current when injured and jump starts or accelerates the wound healing process by attracting the body's repair cells, changing cell membrane permeability and hence cellular secretion, and orientating cell structures. A current is generated between the skin and inner tissues when there is a break in the skin. The current is kept flowing until the open skin defect is repaired. There may be different types of electricity used, controlled by different electrical sources. A moist wound environment is required for capacitatively coupled electrical stimulation, which involves using a surface electrode pad in wet contact (capacitatively coupled) with the external skin surface and/or wound bed. Two electrodes are required to complete the electric circuit and are usually placed over a wet conductive medium in the wound bed and on the skin away from the wound. One of the most safe and effective wavelengths used is monophasic twin peaked high voltage pulsed current (HVPC), allowing for selection of polarity, variation in pulse rates, and very short pulse duration. Significant changes in tissue pH and temperature are avoided, which is good for healing.

## Coding Tips

Medicare covers G0281 and G0282 for the treatment of chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers only. In addition, the use of electrical stimulation will only be covered by Medicare after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician but no less than every 30 days. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100 percent epithelialized wound bed. Electrical stimulation for non-wound purposes (G0283) must be documented in the patient record. Third-party payers may not separately reimburse for this service. Check with the payer for their specific guidelines.

## ICD-10-CM Diagnostic Codes

I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot A ☑

I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle A ☑

I70.45 Atherosclerosis of autologous vein bypass graft(s) of other extremity with ulceration A

I70.541 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of thigh A ☑

I70.542 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf A ☑

I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot A ☑



 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only 

# Correct Coding Initiative Update 28.3



❖Indicates Mutually Exclusive Edit

**0232T** 36415, 36591-36592, 76380, 76942, 76998, 77002, 77012, 77021, 86965, 96523, 99446-99449, 99451-99452

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**0554T** 0555T, 0556T, 0557T

**0555T** No CCI edits apply to this code.

**0556T** No CCI edits apply to this code.

**0557T** No CCI edits apply to this code.

**0559T** 0694T, 76376-76377

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**0561T** 0694T, 76376-76377

**0562T** 0694T, 76376-76377

**0640T** 0493T, 0641T-0642T, 36591-36592, 96523

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**0707T** 0213T, 0216T, 0596T-0597T, 11010❖, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 20526, 20615❖, 29365, 29800, 29805, 29830, 29840, 29860, 29870, 29900, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461-64463, 64479-64505, 64510-64530, 69990, 76000, 76380, 76942, 76998, 77002, 77012, 77021, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, G0463, G0471, J2001

**10060** 0213T, 0216T, 0596T-0597T, 11055-11057, 11401-11406❖, 11421-11426❖, 11441-11471❖, 11600-11606❖, 11620-11646❖, 11719-11730, 11740, 11765, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 20500, 29580-29581, 30000❖, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461-64463, 64479-64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 96523, 97597-97598, 97602-97608, 99155, 99156, 99157,