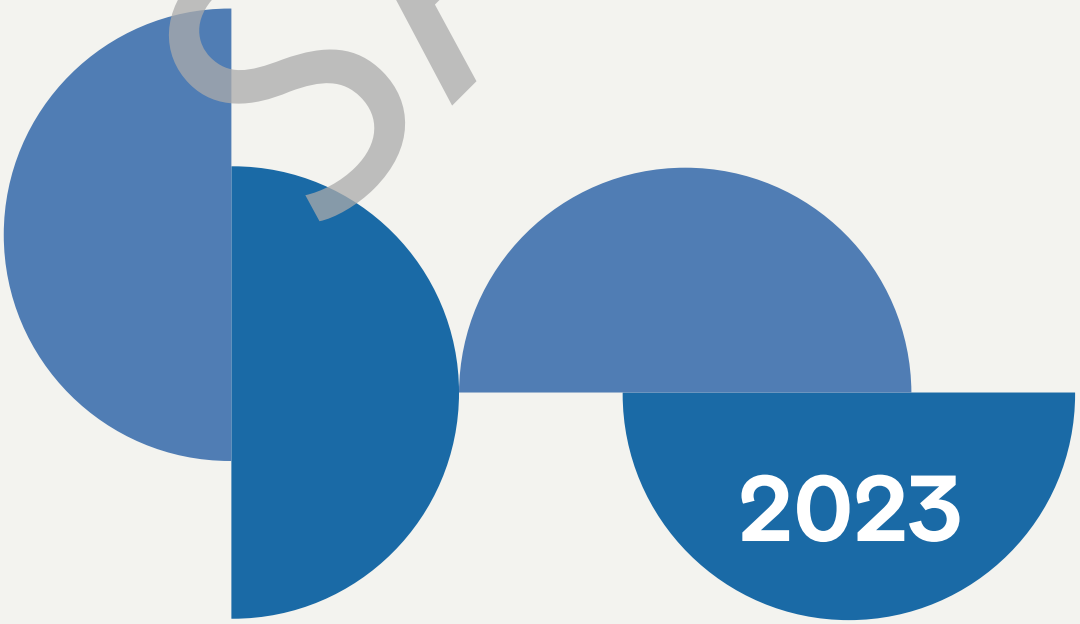
Optum

Coding Companion

Podiatry

A comprehensive illustrated guide to coding and reimbursement



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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 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 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 Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. 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. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

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 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 XX.X, 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 CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX**. 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

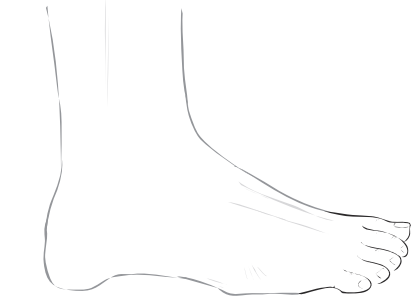
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

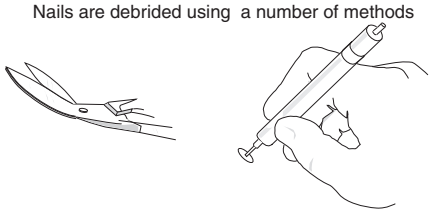
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

11720-11721

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



Nails are debrided using a number of methods



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** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11720	0.32	0.61	0.04	0.97
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 Codes and Descriptions

This edition of *Coding Companion* is updated with CPT 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 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 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.

[ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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 Optum360 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.

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 nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital 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 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 the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

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 E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/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/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/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 exact same subspecialties 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 on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

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 no longer used 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 observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. 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** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	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

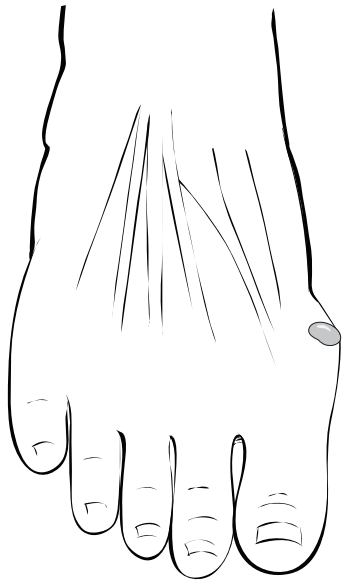
Terms To Know

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 provider/qualified health care professional or another physician/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.

11420-11426

11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm



Excision of a benign lesion of the foot

Explanation

The physician removes a benign skin lesion located on the feet. After administering a local anesthetic, the physician makes a full thickness incision through the dermis with a scalpel, usually in an elliptical shape around and under the lesion. The lesion and a margin of normal tissue are removed. The wound is repaired using a single layer of sutures, chemical or electrocauterization. Complex or layered closure is reported separately, if required. Each lesion removed is reported separately. Report 11420 for an excised diameter 0.5 cm or less; 11421 for 0.6 cm to 1 cm; 11422 for 1.1 cm to 2 cm; 11423 for 2.1 cm to 3 cm; 11424 for 3.1 cm to 4 cm; and 11426 if the excised diameter is greater than 4 cm.

Coding Tips

Excision of a benign lesion requires a full-thickness incision and removal of the lesion and tissue margins. Local anesthesia is included in these services. These procedures include simple (non-layered) repair of the skin and/or subcutaneous tissues. If intermediate repair involving layered closure of deeper subcutaneous or nonmuscle fascia is required, it is reported separately. 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 shaving of an epidermal or a dermal lesion, see 11300–11303. For destruction of a lesion by electrosurgical or other methods, see 17000 et seq. For excision of a malignant lesion, see 11600–11606. For handling or conveyance of a specimen transported to an outside laboratory, see 99000–99001.

ICD-10-CM Diagnostic Codes

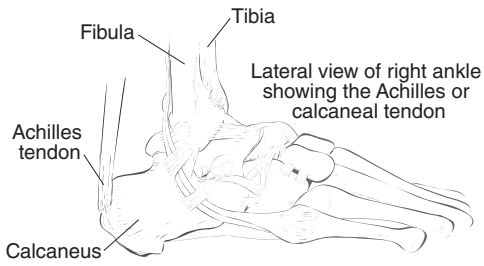
D17.23 Benign lipomatous neoplasm of skin and subcutaneous tissue of right leg ☑
D17.24 Benign lipomatous neoplasm of skin and subcutaneous tissue of left leg ☑
D18.01 Hemangioma of skin and subcutaneous tissue
D22.71 Melanocytic nevi of right lower limb, including hip ☑
D22.72 Melanocytic nevi of left lower limb, including hip ☑
D23.71 Other benign neoplasm of skin of right lower limb, including hip ☑
D23.72 Other benign neoplasm of skin of left lower limb, including hip ☑
D48.5 Neoplasm of uncertain behavior of skin
D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin
I78.1 Nevus, non-neoplastic
L72.0 Epidermal cyst
L72.11 Pilar cyst
L72.12 Trichodermal cyst
L72.2 Steatocystoma multiplex
L72.3 Sebaceous cyst
L72.8 Other follicular cysts of the skin and subcutaneous tissue
L82.0 Inflamed seborrheic keratosis
L82.1 Other seborrheic keratosis
L91.0 Hypertrophic scar
L91.8 Other hypertrophic disorders of the skin
L92.2 Granuloma faciale [eosinophilic granuloma of skin]
L92.3 Foreign body granuloma of the skin and subcutaneous tissue
L92.8 Other granulomatous disorders of the skin and subcutaneous tissue
Q82.5 Congenital non-neoplastic nevus

AMA: **11420** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **11421** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **11422** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **11423** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **11424** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **11426** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16

27605-27606

27605 Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia

27606 general anesthesia



The Achilles tendon is approached through the skin and its attachment to the heel bone is cut

Explanation

The physician performs a percutaneous tenotomy of the Achilles tendon. The physician infiltrates the skin and Achilles tendon with a local anesthetic about 1 cm above the insertion into the calcaneus. A knife blade or tenotome held vertically is inserted through the skin and subcutaneous tissue into the Achilles tendon. The blade is turned medially and laterally and swept back forth, creating a nick in the tendon, until the foot can be dorsiflexed at the ankle. Pressure is applied over the incision for about five minutes. A dressing and long leg cast is applied with the ankle in ten degree dorsiflexion and the knee in maximal extension. Report 27605 if performed with local anesthesia; report 27606 if general anesthesia is required.

Coding Tips

These separate procedures by definition are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services they may be reported. If performed alone, list the code; if performed with other unrelated procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery section, under Musculoskeletal System. For Achilles tendon lengthening, see 27685.

ICD-10-CM Diagnostic Codes

M67.01 Short Achilles tendon (acquired), right ankle ☑

M67.02 Short Achilles tendon (acquired), left ankle ☑

M76.61 Achilles tendinitis, right leg ☑

M76.62 Achilles tendinitis, left leg ☑

AMA: **27605** 2018,Sep,14; 2018,Sep,7 **27606** 2018,Sep,7; 2018,Sep,14

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27605	2.92	6.94	0.27	10.13
27606	4.18	3.25	0.64	8.07
Facility RVU	**Work**	**PE**	**MP**	**Total**
27605	2.92	2.2	0.27	5.39
27606	4.18	3.25	0.64	8.07

	FUD	Status	MUE	Modifiers				IOM Reference
27605	10	A	1(2)	51	50	N/A	80*	None
27606	10	A	1(2)	51	50	62*	N/A	

* with documentation

Terms To Know

Achilles tendon. Tendon attached to the back of the heel bone (calcaneus) that flexes the foot downward.

contracture. Shortening of muscle or connective tissue.

dorsiflexion. Position of being bent toward the extensor side of a limb.

general anesthesia. State of unconsciousness produced by an anesthetic agent or agents, inducing amnesia by blocking the awareness center in the brain, and rendering the patient unable to control protective reflexes, such as breathing.

incision. Act of cutting into tissue or an organ.

lateral. On/to the side.

local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

medial. Middle or midline.

percutaneous. Through the skin.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

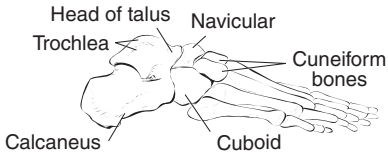
tenosynovitis. Inflammation of a tendon sheath due to infection or disease.

tenotomy. Cutting into a tendon.

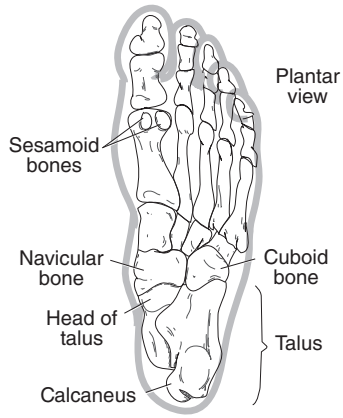
 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

28005

28005 Incision, bone cortex (eg, osteomyelitis or bone abscess), foot



An incision is made into the cortex of a foot bone. Typically a bone abscess is treated or dead bone tissue (osteomyelitis) is removed



Explanation

The physician incises the bone cortex of infected bone in the foot to treat an abscess or osteomyelitis. The physician makes an incision over the affected area. Dissection is carried through the soft tissues to expose the bone. The periosteum is split and reflected from the bone overlying the infected area. A curette may be used to scrape away the abscess or infected portion to healthy bony tissue or drill holes may be made through the cortex into the medullary canal in a window outline around the infected or abscessed bone. The area is drained and debrided of infected bony and soft tissue. The physician irrigates the area with antibiotic solution, the periosteum is closed over the bone, and the soft tissues are sutured closed; or the wound is packed and left open, allowing the area to drain. Secondary closure is performed approximately three weeks later. Dressings are changed daily. A splint may be applied to limit movement.

Coding Tips

Placement of antibiotic-impregnated beads is not reported separately. This code includes any excision of tissues for cultures obtained by the physician. Secondary closure of the surgical wound is reported separately, see 13160. If multiple incision and drainages are performed, report 28005 for each site taken and append modifier 59 or an X{EPSU} modifier. When 28005 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Local anesthesia is included in this service. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery section, under Musculoskeletal system. For incision and drainage of an abscess, infected bursa, or hematoma, see 28001–28003. For open drilling of an osteochondral defect of the talar dome, see 27899.

ICD-10-CM Diagnostic Codes

M86.071 Acute hematogenous osteomyelitis, right ankle and foot ☑
M86.072 Acute hematogenous osteomyelitis, left ankle and foot ☑
M86.171 Other acute osteomyelitis, right ankle and foot ☑
M86.172 Other acute osteomyelitis, left ankle and foot ☑
M86.271 Subacute osteomyelitis, right ankle and foot ☑
M86.272 Subacute osteomyelitis, left ankle and foot ☑
M86.371 Chronic multifocal osteomyelitis, right ankle and foot ☑
M86.372 Chronic multifocal osteomyelitis, left ankle and foot ☑
M86.471 Chronic osteomyelitis with draining sinus, right ankle and foot ☑
M86.472 Chronic osteomyelitis with draining sinus, left ankle and foot ☑
M86.571 Other chronic hematogenous osteomyelitis, right ankle and foot ☑
M86.572 Other chronic hematogenous osteomyelitis, left ankle and foot ☑
M86.671 Other chronic osteomyelitis, right ankle and foot ☑
M86.672 Other chronic osteomyelitis, left ankle and foot ☑
M86.8X7 Other osteomyelitis, ankle and foot
M89.771 Major osseous defect, right ankle and foot ☑
M89.772 Major osseous defect, left ankle and foot ☑
M90.571 Osteonecrosis in diseases classified elsewhere, right ankle and foot ☑
M90.572 Osteonecrosis in diseases classified elsewhere, left ankle and foot ☑
M90.671 Osteitis deformans in neoplastic diseases, right ankle and foot ☑
M90.672 Osteitis deformans in neoplastic diseases, left ankle and foot ☑
M90.871 Osteopathy in diseases classified elsewhere, right ankle and foot ☑
M90.872 Osteopathy in diseases classified elsewhere, left ankle and foot ☑

AMA: **28005** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28005	9.44	6.47	0.87	16.78
Facility RVU	**Work**	**PE**	**MP**	**Total**
28005	9.44	6.47	0.87	16.78

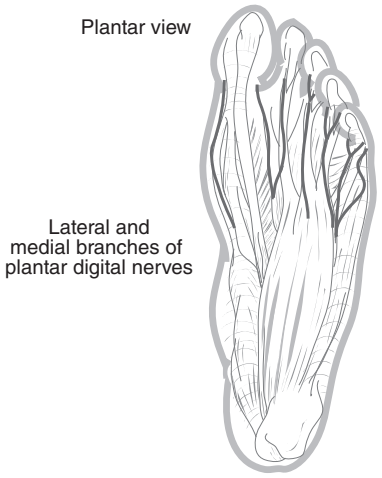
	FUD	Status	MUE	Modifiers				IOM Reference
28005	90	A	3(3)	51	N/A	N/A	N/A	None

* with documentation

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

64726

64726 Decompression; plantar digital nerve



Explanation

The physician decompresses a nerve located at the base of the foot that supplies sensory fibers to one of the toes. The physician makes an incision in the area of nerve tension and locates the nerve. Surrounding soft tissues are dissected from the nerve to release pressure on the nerve.

Coding Tips

Neuroplasty includes external neurolysis and transposition. For internal neurolysis requiring use of an operating microscope, report 64727 in addition to the code for the primary procedure. For decompression of an unspecified nerve, see 64722. Do not report 64726 with 11960. 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.

ICD-10-CM Diagnostic Codes

G57.61	Lesion of plantar nerve, right lower limb ☑
G57.62	Lesion of plantar nerve, left lower limb ☑
G57.63	Lesion of plantar nerve, bilateral lower limbs ☑
S94.31XA	Injury of cutaneous sensory nerve at ankle and foot level, right leg, initial encounter ☑
S94.32XA	Injury of cutaneous sensory nerve at ankle and foot level, left leg, initial encounter ☑
S94.8X1A	Injury of other nerves at ankle and foot level, right leg, initial encounter ☑
S94.8X2A	Injury of other nerves at ankle and foot level, left leg, initial encounter ☑

AMA: **64726** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64726	4.27	3.18	0.38	7.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
64726	4.27	3.18	0.38	7.83

	FUD	Status	MUE	Modifiers				IOM Reference
64726	90	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

causalgia. Condition due to an injury of a peripheral nerve causing burning pain and possible trophic skin changes.

decompression. Release of pressure.

dissect. Cut apart or separate tissue for surgical purposes or for visual or microscopic study.

ganglion. Fluid-filled, benign cyst appearing on a tendon sheath or aponeurosis, frequently connecting to an underlying joint.

lateral. On/to the side.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

lysis. Destruction, breakdown, dissolution, or decomposition of cells or substances by a specific catalyzing agent.

medial. Middle or midline.

operating microscope. Compound microscope with two or more lens systems or several grouped lenses in one unit that provides magnifying power to the surgeon up to 40X.

tarsal tunnel syndrome. Entrapment or compression of the posterior tibial nerve, causing tingling, pain, and numbness in the sole of the foot.

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

G0127

G0127 Trimming of dystrophic nails, any number

Explanation

A physician trims fingernails or toenails usually with scissors, nail cutters, or other instruments when the nails are defective and dystrophic from nutritional or metabolic abnormalities. Report this code for any number of nails trimmed.

Coding Tips

This procedure is reported only once regardless of the number of nails trimmed. 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.

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 ☑
L03.041 Acute lymphangitis of right toe ☑
L03.042 Acute lymphangitis of left toe ☑
L60.0 Ingrowing nail
L60.1 Onycholysis
L60.2 Onychogryphosis
L60.3 Nail dystrophy
L60.4 Beau's lines
L60.5 Yellow nail syndrome
L60.8 Other nail disorders
R68.3 Clubbing of fingers

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0127	0.17	0.52	0.01	0.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0127	0.17	0.04	0.01	0.22

	FUD	Status	MUE	Modifiers				IOM Reference
G0127	0	R	1(2)	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.

paronychia. Infection or cellulitis of nail structures.

G0168

G0168 Wound closure utilizing tissue adhesive(s) only

Explanation

Wound closure done by using tissue adhesive only, not any kind of suturing or stapling, is reported with this code. Tissue adhesives, such as Dermabond, are materials that are applied directly to the skin or tissue of an open wound to hold the margins closed for healing.

Coding Tips

Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. To report extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S81.811A Laceration without foreign body, right lower leg, initial encounter ☑
S91.011A Laceration without foreign body, 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 ☑
S91.211A Laceration without foreign body of right great toe with damage to nail, initial encounter ☑
S91.214A Laceration without foreign body of right lesser toe(s) with damage to nail, initial encounter ☑
S91.311A Laceration without foreign body, right foot, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0168	0.31	3.2	0.05	3.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0168	0.31	0.08	0.05	0.44

	FUD	Status	MUE	Modifiers				IOM Reference
G0168	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

suture. Numerous stitching techniques employed in wound closure.

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

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

0335T 01470, 0213T, 0216T, 0490T, 0510T, 0566T, 0594T-0597T, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 20527-20553, 20560-20606, 20610-20611, 20690, 20692, 20696-20697, 20704, 27610, 27620-27626, 27635, 27640-27641, 27680-27681, 28020, 28050, 28070, 28100, 28116-28118, 28120, 28122, 28220-28226, 28234, 28262, 28300-28304, 28606, 29345-29435, 29505, 29540, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 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, G0463, G0471

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0493T 36591-36592, 96523

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0513T 0213T, 0216T, 0508T, 0596T-0597T, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461-64463, 64479-64505, 64510-64530, 69990, 76881-76882, 76977, 76998-76999, 92012-92014, 93000-93010, 93040-93042, 93318, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449

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 76376-76377

0560T 76376-76377

0561T 76376-76377

0562T 76376-76377

0640T No CCI edits apply to this code.

0641T No CCI edits apply to this code.

0642T No CCI edits apply to this code.

0707T No CCI edits apply to this code.

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