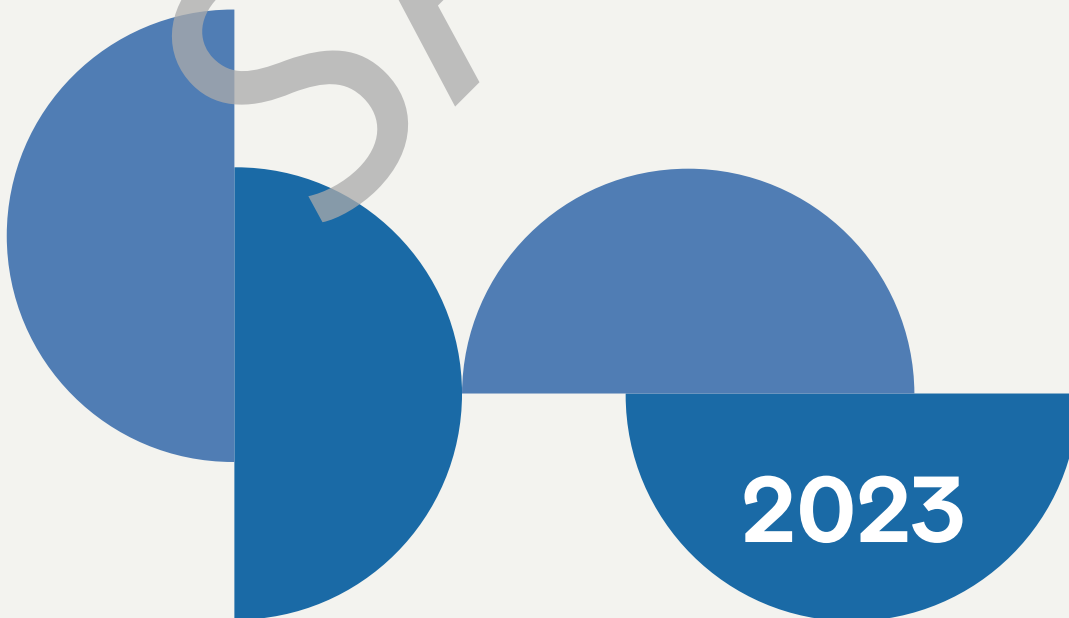


# Orthopaedics: Lower - Hips & Below

A comprehensive illustrated guide to  
coding and reimbursement



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SAMPLE

# Getting Started with Coding Companion

*Coding Companion for Orthopaedics — Lower: Hips and Below* 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 Orthopaedics 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 page 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:

- HCPCS
- Pathology and Laboratory
- Surgery
- Medicine Services
- Radiology
- 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.

# 11055-11057

1

- 11055** Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- 11056** 2 to 4 lesions
- 11057** more than 4 lesions



Depiction of a single corn-like lesion on a common location of the foot

2

## Explanation

The physician removes a benign hyperkeratotic skin lesion such as a corn or callus by cutting, clipping, or paring. Report 11055 when one lesion is removed; 11056 when two to four lesions are removed; and 11057 when more than four lesions are removed.

## 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. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. Modifier Q7, Q8, or Q9 should be used 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 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

- L11.0 Acquired keratosis follicularis
- L84 Corns and callosities
- L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
- L85.2 Keratosis punctata (palmaris et plantaris)
- L86 Keratoderma in diseases classified elsewhere
- L87.0 Keratosis follicularis et parafollicularis in cutem penetrans
- Q82.8 Other specified congenital malformations of skin

## Associated HCPCS Codes

- 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

**AMA:** 11055 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16  
2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16  
11057 2018,Jan,8; 2016,Jan,13; 2015,Jan,16

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE   | MP   | Total |
|------------------|------|------|------|-------|
| <b>11055</b>     | 0.35 | 1.66 | 0.04 | 2.05  |
| <b>11056</b>     | 0.5  | 1.81 | 0.04 | 2.35  |
| <b>11057</b>     | 0.65 | 1.88 | 0.05 | 2.58  |
| Facility RVU     | Work | PE   | MP   | Total |
| <b>11055</b>     | 0.35 | 0.08 | 0.04 | 0.47  |
| <b>11056</b>     | 0.5  | 0.11 | 0.04 | 0.65  |
| <b>11057</b>     | 0.65 | 0.14 | 0.05 | 0.84  |

|              | FUD | Status | MUE  | Modifiers |     |     | IOM Reference |      |
|--------------|-----|--------|------|-----------|-----|-----|---------------|------|
| <b>11055</b> | 0   | R      | 1(2) | 51        | N/A | N/A | N/A           | None |
| <b>11056</b> | 0   | R      | 1(2) | 51        | N/A | N/A | N/A           |      |
| <b>11057</b> | 0   | R      | 1(2) | 51        | N/A | N/A | N/A           |      |

\*with documentation

## Terms To Know

**anomaly.** Irregularity in the structure or position of an organ or tissue.

**benign lesion.** Neoplasm or change in tissue that is not cancerous (nonmalignant).

**callosities.** Localized, hardened patches of overgrowth on the epidermis caused by friction or pressure.

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

**keratoderma.** Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

**keratosis.** Skin condition characterized by a wart-like or callus-type localized overgrowth, hardening, or thickening of the upper skin layer as a result of overproduction of the protein keratin.

**lesion.** Area of damaged tissue that has lost continuity or function, due to disease or trauma. Lesions may be located on internal structures such as the brain, nerves, or kidneys, or visible on the skin.

**paring.** Cutting away an edge or a surface.

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

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## 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:

- ▭ Newborn: 0
- ▭ Pediatric: 0-17
- ▭ Maternity: 9-64
- ▭ 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 (modifier 26) 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.



# 99211-99215

- ▲★99211 Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
- ★99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
- ★99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
- ★99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
- ★99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

## Explanation

Providers report these codes for established 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 excluding the most basic service represented by 99211 that describes an encounter that may not require the presence of a physician or other qualified health care professional. For the remainder of codes within this range, 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/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. Report 99212 for a visit that entails straightforward MDM. If time is used for code selection, 10 to 19 minutes of total time is spent on the day of encounter. Report 99213 for a visit requiring a low level of MDM or 20 to 29 minutes of total time; 99214 for a moderate level of MDM or 30 to 39 minutes of total time; and 99215 for a high level of MDM or 40 to 54 minutes of total time.

## Coding Tips

These codes are used to report office or other outpatient services for an established 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. Code

99211 does not require the presence of a physician or other qualified health care professional. For office or other outpatient services for a new patient, see 99202-99205. 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.

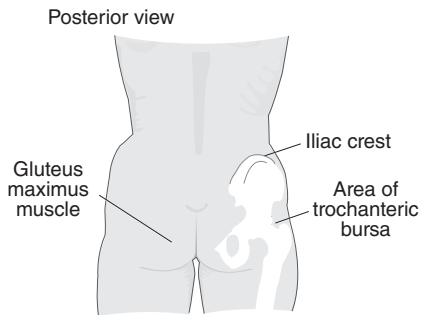
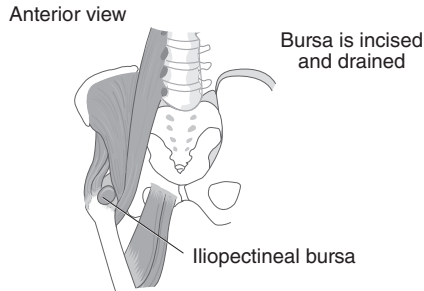
## ICD-10-CM Diagnostic Codes

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:** 99211 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,Nov,12; 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,Mar,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 99212 2020,Sep,14; 2020,Sep,3; 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,9; 2018,Apr,10; 2017,Oct,5; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 99213 2020,Sep,14; 2020,Sep,3; 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 99214 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,Nov,12; 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 99215 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,Nov,12; 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

# 26991

**26991** Incision and drainage, pelvis or hip joint area; infected bursa



## Explanation

The physician drains an infected bursa from the pelvis or hip joint area. The physician makes an incision overlying the site of the bursa. Dissection is carried through the deep subcutaneous tissues and may be continued into the fascia or muscle to expose the infected bursa. The incision may be extended if the mass is larger than expected. When the infected bursa is identified, it is incised and the contents are drained. The area is irrigated and the incision is repaired in layers with sutures, staples, and/or Steri-strips, closed with drains in place, or simply left open to further facilitate drainage of infection.

## Coding Tips

This procedure does not involve incision into the joint capsule (arthrotomy). Secondary closure, when necessary, of the surgical wound is reported separately, see 13160. For arthrotomy, hip, for infection, with drainage, see 27030. For incision and drainage, pelvis or hip joint area, deep abscess or hematoma, see 26990. For a deep incision with opening of bone cortex, see 26992. For incision and drainage procedures, superficial, see 10060-10061.

## ICD-10-CM Diagnostic Codes

- M71.151 Other infective bursitis, right hip
- M71.152 Other infective bursitis, left hip
- M71.159 Other infective bursitis, unspecified hip

**AMA:** 26991 2018, Sep, 7

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE    | MP   | Total |
|------------------|------|-------|------|-------|
| <b>26991</b>     | 7.06 | 12.88 | 1.41 | 21.35 |
| Facility RVU     | Work | PE    | MP   | Total |
| <b>26991</b>     | 7.06 | 7.08  | 1.41 | 15.55 |

|              | FUD | Status | MUE  | Modifiers |     |     | IOM Reference |      |
|--------------|-----|--------|------|-----------|-----|-----|---------------|------|
| <b>26991</b> | 90  | A      | 1(3) | 51        | N/A | N/A | 80*           | None |

\* with documentation

## Terms To Know

**bursa.** Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts. An anatomical structure frequently referenced in orthopedic notes as it may become diseased or need removal.

**dissection.** Separating by cutting tissue or body structures apart.

**fascia.** Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

**incision and drainage.** Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

**irrigation.** To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

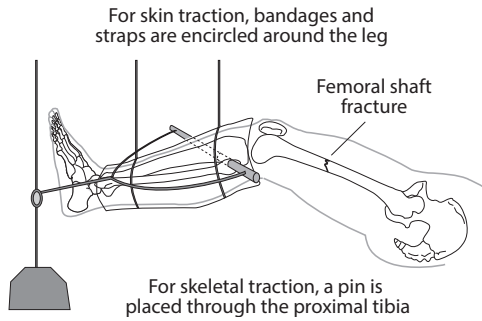
**necrosis.** Death of cells or tissue within a living organ or structure.

**soft tissue.** Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.



# 27502

**27502** Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction



## Explanation

Closed reduction of the fracture is required by manual reduction by the physician or in conjunction with skin or skeletal traction. If skin traction is used, the leg is placed in full extension and bandages and straps are encircled around the leg starting at the foot and extending to the thigh. Weight is added to provide the traction force. The best application of skin traction is to temporarily provide comfort and support to the fractured limb until a definitive form of therapy is available. For skeletal traction, a pin is placed transversely through the proximal tibia with the knee in slight flexion. Traction weight is 15 to 20 pounds, and thereafter may be reduced gradually. If the physician is concerned about accurate reduction, a second pin may be placed through the distal femur, permitting early movement of the knee. Traction can maintain position until bone healing is well established. If traction is not needed, the extremity is placed in a spica cast or cast brace.

## Coding Tips

Femoral fracture codes are site specific. Code 27502 describes a fracture of the shaft (middle portion) of the femur. 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. If application of an external fixation system is required, it is reported separately with 20690 for a uniplane system or 20692 for a multiplane system. For open treatment of a femoral shaft fracture, see 27506–27507. For radiology services, see 73551–73552.

## ICD-10-CM Diagnostic Codes

- M80.051A Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture **A** **✓**
- M84.351A Stress fracture, right femur, initial encounter for fracture **✓**
- M84.451A Pathological fracture, right femur, initial encounter for fracture **✓**
- M84.751A Incomplete atypical femoral fracture, right leg, initial encounter for fracture **✓**
- M84.754A Complete transverse atypical femoral fracture, right leg, initial encounter for fracture **✓**
- M84.757A Complete oblique atypical femoral fracture, right leg, initial encounter for fracture **✓**
- S72.321A Displaced transverse fracture of shaft of right femur, initial encounter for closed fracture **✓**
- S72.331A Displaced oblique fracture of shaft of right femur, initial encounter for closed fracture **✓**

- S72.341A Displaced spiral fracture of shaft of right femur, initial encounter for closed fracture **✓**
- S72.351A Displaced comminuted fracture of shaft of right femur, initial encounter for closed fracture **✓**
- S72.361A Displaced segmental fracture of shaft of right femur, initial encounter for closed fracture **✓**
- S72.391A Other fracture of shaft of right femur, initial encounter for closed fracture **✓**

**AMA:** 27502 2018, Sep, 7; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work  | PE   | MP   | Total |
|------------------|-------|------|------|-------|
| <b>27502</b>     | 11.36 | 8.76 | 2.22 | 22.34 |
| Facility RVU     | Work  | PE   | MP   | Total |
| <b>27502</b>     | 11.36 | 8.76 | 2.22 | 22.34 |

|              | FUD | Status | MUE  | Modifiers |    | IOM Reference |      |
|--------------|-----|--------|------|-----------|----|---------------|------|
| <b>27502</b> | 90  | A      | 1(2) | 51        | 50 | N/A N/A       | None |

\* with documentation

## Terms To Know

**manipulation.** Skillful treatment by hand to reduce fractures and dislocations or provide therapy through forceful passive movement of a joint beyond its active limit of motion.

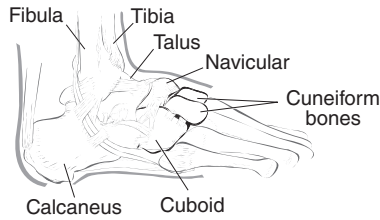
**skeletal traction.** Applying direct pulling force on the long axis of bones by inserted wires or pins and using weights and pulleys to keep the bone in proper alignment.

**skin traction.** Application of a pulling force to a limb accomplished by a device fixed to felt dressings or strappings applied to the body surface.

# 28304-28305

- 28304** Osteotomy, tarsal bones, other than calcaneus or talus;  
**28305** with autograft (includes obtaining graft) (eg, Fowler type)

Lateral view of right ankle



Overhead view of tarsals other than calcaneus and talus

## Explanation

The physician makes an incision over the base of the first metatarsal, and over the second and third metatarsals depending on the extent and type of repair. The physician retracts the tendons and incises the periosteum to expose the tarsal. A sagittal saw is used to remove a wedge of bone. Staples, screws, or Kirschner wires are used for fixation. After the immediate postoperative dressing, immobilization may be applied. Report 28305 when a bone graft is necessary. For this procedure, the physician debrides the intended graft recipient site of the tarsal and a bone graft from the iliac crest or other site is shaped and placed between the prepared surfaces. The physician uses a lamina spreader to place the bone graft. Staples, screws, or wires may be used to secure the bone graft. The tissue and skin are sutured closed. A dressing is applied and the area may be immobilized.

## Coding Tips

For osteotomy, calcaneus, see 28300. For osteotomy, talus, see 28302. For radiology services, see 73600–73630.

## ICD-10-CM Diagnostic Codes

- M21.171 Varus deformity, not elsewhere classified, right ankle
- M21.172 Varus deformity, not elsewhere classified, left ankle
- M92.61 Juvenile osteochondrosis of tarsus, right ankle
- M92.62 Juvenile osteochondrosis of tarsus, left ankle
- Q66.11 Congenital talipes calcaneovarus, right foot
- Q66.12 Congenital talipes calcaneovarus, left foot
- Q66.31 Other congenital varus deformities of feet, right foot
- Q66.32 Other congenital varus deformities of feet, left foot
- Q66.41 Congenital talipes calcaneovalgus, right foot
- Q66.42 Congenital talipes calcaneovalgus, left foot
- Q66.71 Congenital pes cavus, right foot
- Q66.72 Congenital pes cavus, left foot
- Q66.89 Other specified congenital deformities of feet

**AMA:** 28304 2002, Apr, 13 28305 2002, Apr, 13

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work  | PE    | MP   | Total |
|------------------|-------|-------|------|-------|
| <b>28304</b>     | 9.41  | 13.79 | 1.28 | 24.48 |
| <b>28305</b>     | 10.77 | 7.63  | 1.45 | 19.85 |
| Facility RVU     | Work  | PE    | MP   | Total |
| <b>28304</b>     | 9.41  | 7.12  | 1.28 | 17.81 |
| <b>28305</b>     | 10.77 | 7.63  | 1.45 | 19.85 |

|              | FUD | Status | MUE  | Modifiers |    |     |    | IOM Reference |
|--------------|-----|--------|------|-----------|----|-----|----|---------------|
| <b>28304</b> | 90  | A      | 1(3) | 51        | 50 | 62* | 80 | None          |
| <b>28305</b> | 90  | A      | 1(3) | 51        | 50 | 62* | 80 |               |

\* with documentation

## Terms To Know

**autograft.** Any tissue harvested from one anatomical site of a person and grafted to another anatomical site of the same person. Most commonly, blood vessels, skin, tendons, fascia, and bone are used as autografts.

**fixation.** Act or condition of being attached, secured, fastened, or held in position.

**flexion.** Act of bending or being bent causing a decreased angle of a joint.

**graft.** Tissue implant from another part of the body or another person.

**osteotomy.** Excision of bone.

**osteochondrosis.** Disease manifested by degeneration or necrosis of the growth plate or ossification centers of bones in children, followed by regenerating and reossification.

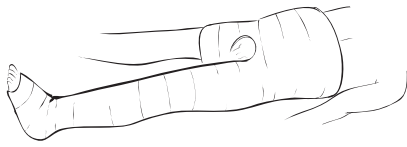
**osteotomy.** Surgical cutting of a bone.

**periosteum.** Double-layered connective membrane on the outer surface of bone.

**talipes equinovarus.** Deformity in which the heel is turned inward, the foot is plantar flexed with the arch raised, causing the ball of the foot to bear the weight of the body; usual clubfoot formation.

# 29305-29325

**29305** Application of hip spica cast; 1 leg  
**29325** 1 and one-half spica or both legs



Example of a one-and-one-half spica hip cast

## Explanation

The physician applies a hip spica cast. The hip spica cast is ideal for patients of all ages who may have hip problems ranging from fractures to dislocations. The physician applies cast padding to the lower torso and hips and extends this down the affected leg in 29305. It may extend below the knee depending on the physician's preference and the extent of hip immobilization desired. The hip is placed at the desired angle and casting material is placed over the padding material and allowed to dry. Report 29325 if the physician applies a one and one-half spica or a cast that envelopes both legs.

## Coding Tips

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 a body cast, including thighs, see 29044–29046.

## ICD-10-CM Diagnostic Codes

- M21.151 Varus deformity, not elsewhere classified, right hip
- M24.451 Recurrent dislocation, right hip
- Q65.01 Congenital dislocation of right hip, unilateral

**AMA:** 29305 2018,Jan,8; 2018,Jan,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16  
 29325 2018,Jan,8; 2018,Jan,3; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

## Relative Value Units/Medicare Edits

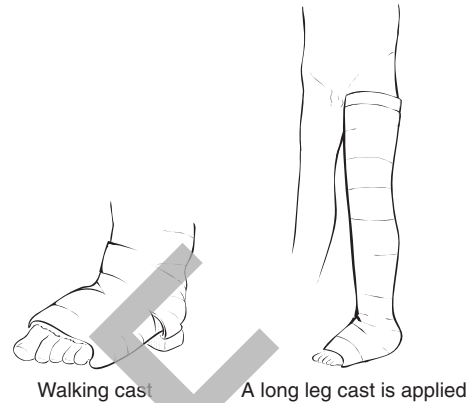
| Non-Facility RVU | Work | PE   | MP   | Total |
|------------------|------|------|------|-------|
| <b>29305</b>     | 2.03 | 4.72 | 0.42 | 7.17  |
| <b>29325</b>     | 2.32 | 5.13 | 0.46 | 7.91  |
| Facility RVU     | Work | PE   | MP   | Total |
| <b>29305</b>     | 2.03 | 2.17 | 0.42 | 4.62  |
| <b>29325</b>     | 2.32 | 2.38 | 0.46 | 5.16  |

|              | FUD | Status | MUE  | Modifiers |     |     |     | IOM Reference |
|--------------|-----|--------|------|-----------|-----|-----|-----|---------------|
| <b>29305</b> | 0   | A      | 1(3) | 51        | N/A | N/A | 80* | None          |
| <b>29325</b> | 0   | A      | 1(3) | 51        | N/A | N/A | 80* |               |

\* with documentation

# 29345-29358

**29345** Application of long leg cast (thigh to toes);  
**29355** walker or ambulatory type  
**29358** Application of long leg cast brace



Walking cast

A long leg cast is applied

## Explanation

In 29345-29355, 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. In 29358, the physician places a metal or plastic support (with or without a hinge) on either side of the knee. Casting material is applied over the supports to hold them in place. The cast allows the knee to bend and straighten while stabilizing the knee during side-to-side movement. Code with caution: this cast is rarely applied, having been replaced by a prefabricated long leg brace.

## Coding Tips

Code with caution: the long-leg cast bracing technique (29358) is rarely performed, having been replaced by a prefabricated long leg brace. 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.

## ICD-10-CM Diagnostic Codes

- M22.01 Recurrent dislocation of patella, right knee
- M24.361 Pathological dislocation of right knee, not elsewhere classified
- M80.051A Age-related osteoporosis with current pathological fracture, right femur, initial encounter for fracture
- M84.751A Incomplete atypical femoral fracture, right leg, initial encounter for fracture
- S72.351A Displaced comminuted fracture of shaft of right femur, initial encounter for closed fracture
- S72.421A Displaced fracture of lateral condyle of right femur, initial encounter for closed fracture
- S72.431A Displaced fracture of medial condyle of right femur, initial encounter for closed fracture
- S72.441A Displaced fracture of lower epiphysis (separation) of right femur, initial encounter for closed fracture
- S72.451A Displaced supracondylar fracture without intracondylar extension of lower end of right femur, initial encounter for closed fracture

# Correct Coding Initiative Update 27.3

◆Indicates Mutually Exclusive Edit

- 0054T** 0213T, 0216T, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76000, 76380, 76942, 76998, 77001-77002, 77011-77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0055T** 0213T, 0216T, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76000, 76380, 76942, 76998, 77001-77002, 77011-77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0101T** 0213T, 0216T, 0508T, 0512T, 0513T, 36000, 36410, 36591-36592, 43752, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76881-76882, 76977, 76998-76999, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0102T** 0101T\*, 0213T, 0216T, 0508T, 0512T\*, 36000, 36410, 36591-36592, 43752, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 76881-76882, 76977, 76998-76999, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452
- 0200T** 01935-01936, 0213T, 0216T, 0333T, 0464T, 0596T-0597T, 10005, 10007, 10009, 10011, 10021, 11000-11006, 11042-11047, 20220-20225, 20240, 22310-22315, 22505, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 38220, 38222-38230, 38232, 43752, 51701-51703, 61650, 62322-62323, 62326-62327, 63707, 63709, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75872, 76000, 77002-77003, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0471
- 0201T** 01935-01936, 0200T, 0213T, 0216T, 0333T, 0464T, 0596T-0597T, 10005, 10007, 10009, 10011, 10021, 11000-11006, 11042-11047, 20220-20225, 20240, 22310-22315, 22505, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 38220, 38222-38230, 38232, 43752, 51701-51703, 61650, 62322-62323, 62326-62327, 63707, 63709, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75872, 76000, 77002-77003, 92652-92653, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0453, G0471
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- 0215T** 0333T, 0464T, 0596T-0597T, 36591-36592, 51701-51703, 76000, 76380, 76800, 76942, 76998, 77001-77003, 77012, 77021, 92652-92653, 95822, 95860-95870, 95907-95913, 95925-95933, 95937-95940, 96523, 99446-99449, 99451-99452, G0453, G0471
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# CPT Index

## A

### Ablation

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