Optum

Coding Companion

Family Practice/ Pediatrics

A comprehensive illustrated guide to coding and reimbursement

2026

optumcoding.com

Contents

Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

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

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 30.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2026 edition password is: **XXXXX** Log in frequently to ensure you receive the most current updates.

Index

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

65205 Removal of foreign body, external eye; conjunctival superficial

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

Conjunctiva
Foreign Body Removal, 65205-65210

or **Eye**
Removal
Foreign Body
Superficial, 65205

or **Foreign Body**
Removal
External Eye, 65205

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 xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

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

Professional and Technical Component

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

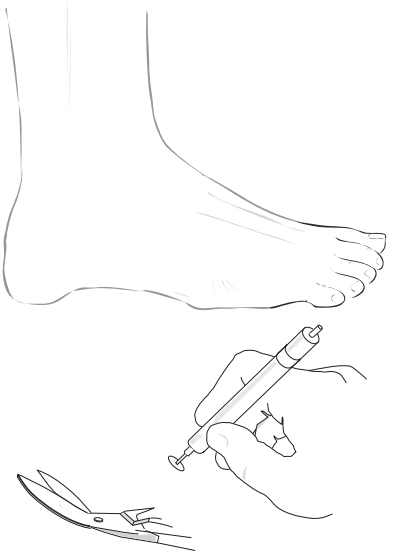
Sample Page and Key

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

11720-11721

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

Nails are debrided using a number of methods



Explanation

The physician debrides fingernails or 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

For trimming of nondystrophic nails, see 11719. These codes are reported only once regardless of the number of nails that are trimmed. For the trimming of dystrophic nails, see G0127. 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. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. 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 physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B35.1 Tinea unguium
B37.2 Candidiasis of skin and nail
L03.011 Cellulitis of right finger ☑
L03.012 Cellulitis of left finger ☑
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

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11720	0.32	0.64	0.03	0.99
11721	0.54	0.76	0.04	1.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
11720	0.32	0.07	0.03	0.42
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	None
11721	0	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

candidiasis. Yeast infection most caused by the fungus *Candida albicans*. It commonly occurs in the vagina but affects any moist skin or mucus membrane.

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

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

paronychia. Infection or cellulitis of nail structures.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2026.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2026.
- ▲ This CPT code description is revised for 2026.
- ✚ This CPT code is an add-on code.

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

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

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 a common method of performing each procedure.

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ 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 2025.

The 2026 Medicare edits were not available at the time this book went to press. Updated 2026 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2026 edition password is **XXXXX**.

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.

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, 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. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

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** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Oct; 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

	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

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

11055-11057

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

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. 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 providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For destruction of a benign or a premalignant lesion, see 17000–17111. 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. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B07.0 Plantar wart
B07.8 Other viral warts
L11.0 Acquired keratosis follicularis
L84 Corns and callosities
L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
L85.2 Keratosis punctata (palmaris et plantaris)
L85.8 Other specified epidermal thickening
L85.9 Epidermal thickening, unspecified
L86 Keratoderma in diseases classified elsewhere
L87.0 Keratosis follicularis et parafollicularis in cutem penetrans
Q82.8 Other specified congenital malformations of skin

AMA: **11055** 2024,Sep; 2022,Feb **11056** 2022,Feb **11057** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.76	0.03	2.14
11056	0.5	1.94	0.04	2.48
11057	0.65	2.01	0.05	2.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
11055	0.35	0.08	0.03	0.46
11056	0.5	0.11	0.04	0.65
11057	0.65	0.15	0.05	0.85

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

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

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

callus. Tissue formation at the site of a fracture that establishes continuity between the fractured ends of the bone. The initial provisional callus, which is comprised of fibrous tissue and cartilage, is eventually absorbed and replaced by osseous tissue (definitive callus).

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

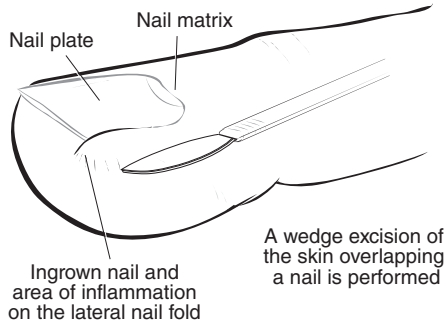
hyperkeratosis. Thickening of the outer layer of the skin because of overproduction of the protein keratin.

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.

11765

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



Explanation

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

Coding Tips

Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For excision of a nail and nail matrix, partial or complete, for permanent removal, see 11750. For avulsion of a nail plate, see 11730–11732. Some payers may require the use of HCPCS Level II modifiers FA–F9 or TA–T9 to identify the specific nail involved. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L60.0 Ingrowing nail

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11765	1.22	3.68	0.1	5.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
11765	1.22	1.48	0.1	2.8

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

* with documentation

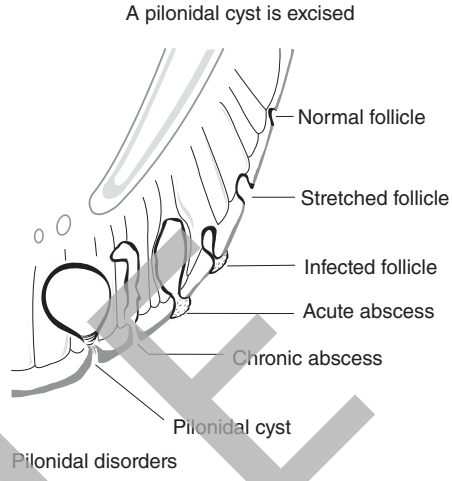
Terms To Know

dressing. Material applied to a wound or surgical site for protection, absorption, or drainage of the area.

nail fold. Nail wall at the side and proximal end of the nail plate covered by a skin fold.

11770-11772

11770 Excision of pilonidal cyst or sinus; simple
11771 extensive
11772 complicated



Explanation

A pilonidal cyst or sinus is entrapped epithelial tissue located in the sacrococcygeal region above the buttocks. These lesions are usually associated with ingrown hair. A sinus cavity is present and may have a fluid-producing cystic lining. With a small or simple sinus in 11770, the physician uses a scalpel to completely excise the involved tissue. The wound is sutured in a single layer. In 11771, an extensive sinus is present superficial to the fascia overlying the sacrum but with subcutaneous extensions. The physician uses a scalpel to completely excise the cystic tissue. The wound may be sutured in several layers. In 11772, the sinus involves many subcutaneous extensions superficial to the fascia overlying the sacrum. The physician uses a scalpel to completely excise the cystic tissue. Local soft tissue flaps (i.e., Z-plasty, Y-V plasty, myofasciocutaneous flap) may be required for closure of a large defect or the wound may be left open to heal by granulation.

Coding Tips

Closure of the defect is included in this procedure and should not be reported separately. For incision and drainage of a pilonidal cyst, see 10080–10081. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

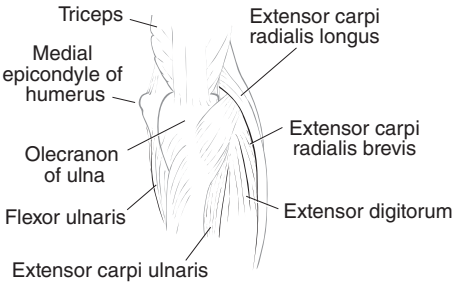
ICD-10-CM Diagnostic Codes

L05.01 Pilonidal cyst with abscess
L05.02 Pilonidal sinus with abscess
L05.91 Pilonidal cyst without abscess
L05.92 Pilonidal sinus without abscess

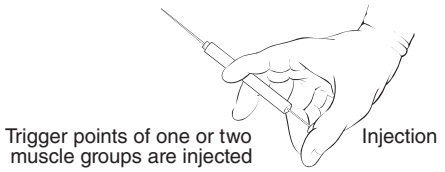
AMA: **11770** 2022,Feb; 2021,Aug **11771** 2022,Feb; 2021,Aug **11772** 2022,Feb; 2021,Aug

20552-20553

20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553 single or multiple trigger point(s), 3 or more muscles



Posterior view, right elbow, superficial dissection



Explanation

The physician injects a therapeutic agent into a single or multiple trigger point of one or two muscles in 20552 and into a single or multiple trigger point for three or more muscles in 20553. Trigger points are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted, and the medicine is injected into the trigger point. The injection may be done using image guidance, which is reported separately. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent. The injection procedure is repeated at the other trigger points for multiple sites.

Coding Tips

Local anesthesia is included in these services. If imaging guidance is performed, see 76942, 77002, and 77021. Do not report these codes in addition to 20560 or 20561 when the same muscles are being treated. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

G44.211 Episodic tension-type headache, intractable
G44.219 Episodic tension-type headache, not intractable
G44.221 Chronic tension-type headache, intractable
G44.229 Chronic tension-type headache, not intractable
G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.18 Other acute postprocedural pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M25.511 Pain in right shoulder ☑
M25.521 Pain in right elbow ☑
M25.531 Pain in right wrist ☑
M25.541 Pain in joints of right hand ☑
M25.551 Pain in right hip ☑
M25.561 Pain in right knee ☑
M25.571 Pain in right ankle and joints of right foot ☑
M26.621 Arthralgia of right temporomandibular joint ☑
M54.2 Cervicalgia
M54.51 Vertebrogenic low back pain
M54.59 Other low back pain
M72.2 Plantar fascial fibromatosis
M79.11 Myalgia of mastication muscle
M79.12 Myalgia of auxiliary muscles, head and neck
M79.601 Pain in right arm ☑
M79.604 Pain in right leg ☑
M79.621 Pain in right upper arm ☑
M79.631 Pain in right forearm ☑
M79.641 Pain in right hand ☑
M79.644 Pain in right finger(s) ☑
M79.651 Pain in right thigh ☑
M79.661 Pain in right lower leg ☑
M79.671 Pain in right foot ☑
M79.674 Pain in right toe(s) ☑
M79.7 Fibromyalgia

AMA: **20552** 2023,Jan; 2022,Jul; 2021,Oct; 2020,Feb; 2018,Dec **20553** 2024,May; 2023,Jan; 2021,Oct; 2020,Feb; 2018,Dec

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20552	0.66	0.84	0.08	1.58
20553	0.75	0.98	0.09	1.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
20552	0.66	0.36	0.08	1.1
20553	0.75	0.41	0.09	1.25

	FUD	Status	MUE	Modifiers				IOM Reference
20552	0	A	1(2)	51	N/A	N/A	N/A	None
20553	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

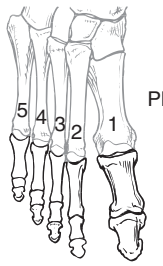
ligament. Band or sheet of fibrous tissue that connects the articular surfaces of bones or supports visceral organs.

trigger point. Focal, discrete spot of hypersensitivity identified within bands of muscle that causes local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers.

28490-28495

28490 Closed treatment of fracture great toe, phalanx or phalanges; without manipulation

28495 with manipulation



Phalanges (dark)

A manipulation technique to reduce a fracture of the great toe. Similar techniques may be used on other toes

A fracture of the great toe, a phalanx or phalanges, is treated in a closed fashion

Explanation

The physician treats a fracture of the big toe involving one or both of the bones without any open surgery and with or without manipulation of the bones. In 28490, separately reportable x-rays confirm a fracture or fractures of the bones in the big toe with the fragments in an acceptable position for healing. The physician places a cast, sling, or brace on the toe and foot as needed. In 28495, separately reportable x-rays of the big toe confirm a fracture or fracture of the bones in the big toe in an unacceptable position. With the patient under anesthesia as required, the physician pulls or pushes on the toe and foot to restore the bony pieces to their proper place. X-rays are taken to ensure that the fracture is aligned correctly. A cast, splint, or brace is placed on the toe and foot.

Coding Tips

These codes report closed treatment of a fracture of the great toe only. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For closed treatment of a fracture of other than the great toe, see 28510–28515. For radiology services, see 73620–73630 and 73660. For radiology services, add modifier 26 to identify the professional component only; if the physician owns the equipment, both components may be reported. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

M80.071A Age-related osteoporosis with current pathological fracture, right ankle and foot, initial encounter for fracture A ☑

M80.871A Other osteoporosis with current pathological fracture, right ankle and foot, initial encounter for fracture ☑

M84.377A Stress fracture, right toe(s), initial encounter for fracture ☑

M84.477A Pathological fracture, right toe(s), initial encounter for fracture ☑

M84.574A Pathological fracture in neoplastic disease, right foot, initial encounter for fracture ☑

M84.674A Pathological fracture in other disease, right foot, initial encounter for fracture ☑

S92.411A Displaced fracture of proximal phalanx of right great toe, initial encounter for closed fracture ☑

S92.414A Nondisplaced fracture of proximal phalanx of right great toe, initial encounter for closed fracture ☑

S92.421A Displaced fracture of distal phalanx of right great toe, initial encounter for closed fracture ☑

S92.424A Nondisplaced fracture of distal phalanx of right great toe, initial encounter for closed fracture ☑

S92.491A Other fracture of right great toe, initial encounter for closed fracture ☑

S99.211A Salter-Harris Type I physeal fracture of phalanx of right toe, initial encounter for closed fracture ☑

S99.221A Salter-Harris Type II physeal fracture of phalanx of right toe, initial encounter for closed fracture ☑

S99.231A Salter-Harris Type III physeal fracture of phalanx of right toe, initial encounter for closed fracture ☑

S99.241A Salter-Harris Type IV physeal fracture of phalanx of right toe, initial encounter for closed fracture ☑

S99.291A Other physeal fracture of phalanx of right toe, initial encounter for closed fracture ☑

AMA: **28490** 2022,May **28495** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28490	1.17	3.07	0.16	4.4
28495	1.68	3.69	0.19	5.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
28490	1.17	2.54	0.16	3.87
28495	1.68	2.75	0.19	4.62

	FUD	Status	MUE	Modifiers				IOM Reference
28490	90	A	1(2)	51	50	N/A	N/A	None
28495	90	A	1(2)	51	50	N/A	N/A	

* with documentation

Terms To Know

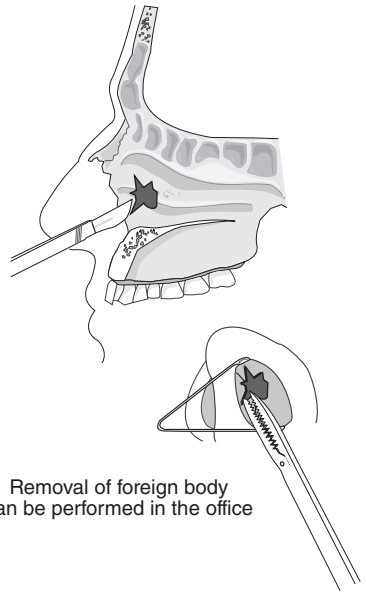
closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation and with or without traction.

pathologic fracture. Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.

phalanx. Bones of the digits (fingers or toes).

30300

30300 Removal foreign body, intranasal; office type procedure



Explanation

The physician removes a foreign body from the inside of the nasal cavity in the office setting. Foreign bodies are defined as objects not normally found in the body. An object may be embedded in normal tissue as a result of some type of trauma. Topical vasoconstrictive agents and local anesthesia are applied to the nasal mucosa. A small incision may be necessary to access the foreign body. Blunt dissection and retrieval of the object is performed with hemostats or forceps. Sutures may close the mucosa in a single layer if the size of the dissection requires.

Coding Tips

Topical vasoconstrictive agents and local anesthesia are not reported separately. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S01.22XA Laceration with foreign body of nose, initial encounter
S01.24XA Puncture wound with foreign body of nose, initial encounter
T17.1XXA Foreign body in nostril, initial encounter

Relative Value Units/Medicare Edits

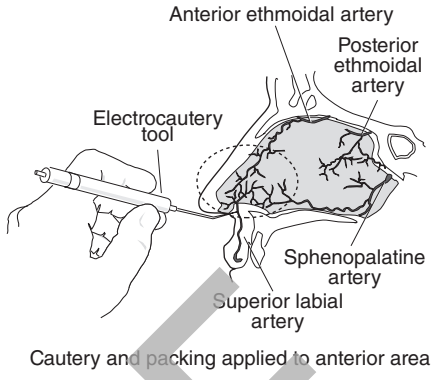
Non-Facility RVU	Work	PE	MP	Total
30300	1.09	5.09	0.16	6.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
30300	1.09	2.47	0.16	3.72

	FUD	Status	MUE	Modifiers				IOM Reference
30300	10	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

30901

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method



Explanation

To control a less serious nosebleed, the physician applies electrical or chemical coagulation or packing materials to the anterior (front) section of the nose. Only limited electrical or chemical coagulation is used.

Coding Tips

This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Local anesthesia is included in this service. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

J95.71 Accidental puncture and laceration of a respiratory system organ or structure during a respiratory system procedure
J95.72 Accidental puncture and laceration of a respiratory system organ or structure during other procedure
J95.830 Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure
J95.831 Postprocedural hemorrhage of a respiratory system organ or structure following other procedure
R04.0 Epistaxis

AMA: **30901** 2020,Oct; 2020,Jul

Relative Value Units/Medicare Edits

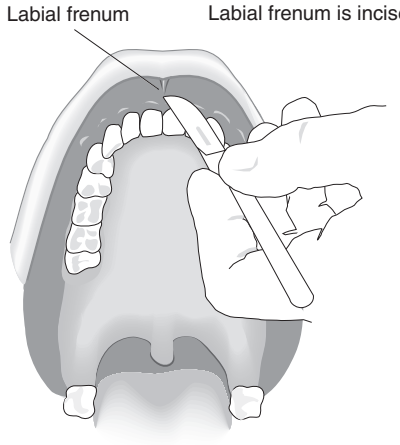
Non-Facility RVU	Work	PE	MP	Total
30901	1.1	3.41	0.19	4.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
30901	1.1	0.4	0.19	1.69

	FUD	Status	MUE	Modifiers				IOM Reference
30901	0	A	1(3)	51	50	N/A	N/A	None

* with documentation

40806

40806 Incision of labial frenum (frenotomy)



Explanation

The physician performs a frenotomy by incising the labial frenum. The labial frenum is a connecting fold of mucous membrane that joins the lip to the gums at the inside midcenter. This procedure is often performed to release tension on the frenum and surrounding tissues. The frenum is simply incised and not removed.

Coding Tips

When the labial frenum is attached close to the crest of the alveolar ridge, it can interfere with tooth eruption or wearing of an upper denture. Local anesthesia is included in this service. For excision of frenum (frenectomy), see 40819. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

Q38.0 Congenital malformations of lips, not elsewhere classified
Q38.1 Ankyloglossia

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40806	0.31	2.64	0.05	3.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
40806	0.31	0.53	0.05	0.89

	FUD	Status	MUE	Modifiers				IOM Reference
40806	0	A	2(2)	51	N/A	N/A	80*	None

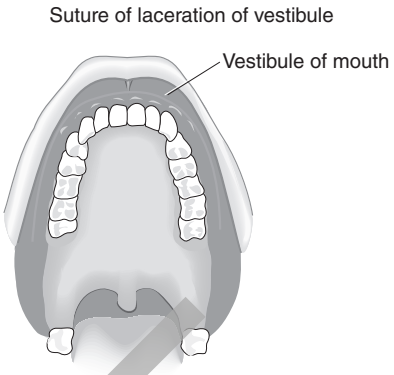
* with documentation

Terms To Know

labial frenum. Connecting fold of mucous membrane that joins the upper or lower lip to the gums at the inside midcenter.

40830

40830 Closure of laceration, vestibule of mouth; 2.5 cm or less



Explanation

The physician sutures a laceration of the vestibule of the mouth measuring 2.5 cm or less in length. The physician performs a simple closure without submucosal sutures or tissue rearrangement.

Coding Tips

When 40830 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 these services. For repair of a laceration of lips and/or mucous membranes, simple, see 12011; intermediate, see 12051. 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

S01.511A Laceration without foreign body of lip, initial encounter
S01.512A Laceration without foreign body of oral cavity, initial encounter
S01.521A Laceration with foreign body of lip, initial encounter
S01.522A Laceration with foreign body of oral cavity, initial encounter
S01.551A Open bite of lip, initial encounter
S01.552A Open bite of oral cavity, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40830	1.82	4.7	0.21	6.73
Facility RVU	**Work**	**PE**	**MP**	**Total**
40830	1.82	2.34	0.21	4.37

	FUD	Status	MUE	Modifiers				IOM Reference
40830	10	A	2(3)	51	N/A	N/A	80*	None

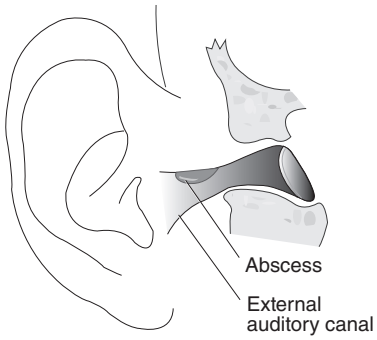
* with documentation

Terms To Know

vestibule of the mouth. Mucosal and submucosal tissue of the lips and cheeks within the oral cavity, not including the dentoalveolar structures.

69020

69020 Drainage external auditory canal, abscess



Explanation

The physician makes an incision in the skin and drains an abscess in the external auditory canal. Occasionally, packing is inserted to absorb the drainage and facilitate healing. Usually no further treatment is needed and no closure is required.

Coding Tips

Local anesthesia is included in this service. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H60.311 Diffuse otitis externa, right ear ☑
H60.321 Hemorrhagic otitis externa, right ear ☑
H60.391 Other infective otitis externa, right ear ☑
H60.41 Cholesteatoma of right external ear ☑
H60.511 Acute actinic otitis externa, right ear ☑
H60.521 Acute chemical otitis externa, right ear ☑
H60.531 Acute contact otitis externa, right ear ☑
H60.541 Acute eczematoid otitis externa, right ear ☑
H60.551 Acute reactive otitis externa, right ear ☑
H60.591 Other noninfective acute otitis externa, right ear ☑
H60.8X1 Other otitis externa, right ear ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69020	1.53	5.26	0.22	7.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
69020	1.53	2.61	0.22	4.36

	FUD	Status	MUE	Modifiers				IOM Reference
69020	10	A	1(3)	51	50	N/A	N/A	None

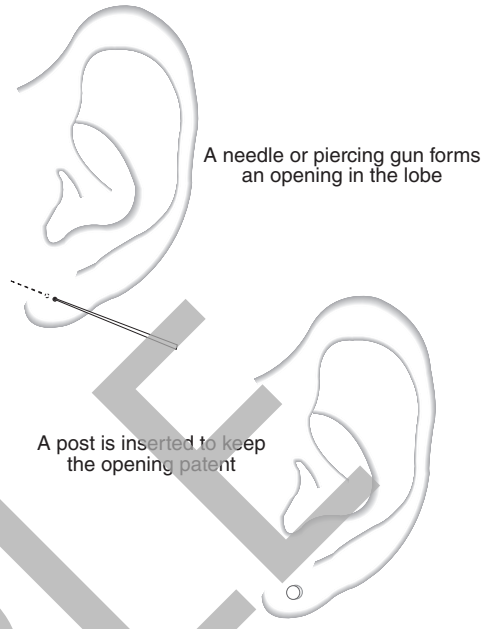
* with documentation

Terms To Know

external auditory canal/meatus. External channel that leads from the opening in the external ear to the tympanic membrane (eardrum).

69090

69090 Ear piercing



Explanation

The physician or technician uses a sharp instrument such as a sterile needle or a piercing gun to form an opening in the ear lobe. After the puncture is complete, the area is cleaned with a disinfectant and an earring is inserted to keep the opening patent. No further treatment is usually necessary.

Coding Tips

Because this procedure is usually not done out of medical necessity, the patient may be responsible for charges. Verify with the insurance carrier for coverage.

ICD-10-CM Diagnostic Codes

Z41.3 Encounter for ear piercing

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69090	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
69090	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
69090	N/A	N	0(3)	N/A	N/A	N/A	N/A	None

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

90460-90461

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

\+ **90461** each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

Explanation

The physician or other qualified health care professional instructs the patient or family on the benefits and risks related to the vaccine or toxoid. The physician counsels the patient or family regarding signs and symptoms of adverse effects and when to seek medical attention for any adverse effects. A physician, nurse, or medical assistant administers an immunization by any route to the patient. It may be a single vaccine or a combination vaccine/toxoid in one immunization administration (e.g., diphtheria, pertussis, and tetanus toxoids are in a single DPT immunization). Report 90460 for the first or only vaccine/toxoid component. Report 90461 for each additional component. These codes report immunization administration to patients 18 years of age or younger.

Coding Tips

These codes should be reported for immunization administration when the patient is 18 years of age or younger and the patient or family has received face-to-face vaccine counseling by a physician or other qualified health care professional. Do not report 90460-90461 with 91304 or 91318-91322, unless a SARS-CoV-2 vaccine/toxoid product and a minimum of one vaccine/toxoid from 90476-90759 are given during the same encounter. For immunization administration for a patient who is older than 18 years of age or for a patient of any age who does not receive vaccine counseling, see 90471–90474. For immunization administration for SARS-CoV-2 [COVID-19], see 90480.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90460** 2024,Nov; 2023,Jul; 2023,May; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2021,Apr; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Jan; 2018,Nov **90461** 2024,Nov; 2024,Feb; 2023,May; 2023,Feb; 2022,Jul; 2021,Oct; 2021,Jun; 2021,May; 2021,Apr; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Jan; 2018,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90460	0.24	0.43	0.02	0.69
90461	0.18	0.07	0.01	0.26
Facility RVU	**Work**	**PE**	**MP**	**Total**
90460	0.24	0.43	0.02	0.69
90461	0.18	0.07	0.01	0.26

	FUD	Status	MUE	Modifiers				IOM Reference
90460	N/A	A	9(3)	N/A	N/A	N/A	80*	None
90461	N/A	A	8(3)	N/A	N/A	N/A	80*	

* with documentation

90471-90472

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

\+ **90472** each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Explanation

A physician, nurse, or medical assistant administers an injectable (percutaneous, intradermal, subcutaneous, or intramuscular) immunization to the patient. It may be a single vaccine or a combination vaccine/toxoid in one immunization administration (e.g., diphtheria, pertussis, and tetanus toxoids are in a single DPT immunization). Report 90471 for one vaccine and 90472 for each additional vaccine (single or combination vaccine/toxoid).

Coding Tips

Report these services for immunization administration of any vaccine, other than SARS-CoV-2 [COVID-19] vaccines, that does not include face-to-face physician or other qualified health care professional counseling of the patient or caregiver during vaccine administration or for administration of vaccines to patients older than 18 years of age. Do not report 90471 with 90473. Report 90472 in addition to 90460, 90471, or 90473. Do not report 90471-90472 with 91304 or 91318-91322, unless a SARS-CoV-2 vaccine/toxoid product and a minimum of one vaccine/toxoid from 90476-90759 are given during the same encounter. For immunization administration for a patient 18 years of age or younger and the patient or family has received face-to-face vaccine counseling by a physician or other qualified health care professional, see 90460–90461. For immunization administration for SARS-CoV-2 [COVID-19], see 90480.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90471** 2024,Oct; 2024,Feb; 2023,May; 2023,Feb; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2020,Nov; 2020,Jan; 2019,Jun; 2018,Nov **90472** 2024,Oct; 2024,Feb; 2023,May; 2023,Feb; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2020,Nov; 2020,Jan; 2018,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90471	0.17	0.44	0.01	0.62
90472	0.15	0.28	0.01	0.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
90471	0.17	0.44	0.01	0.62
90472	0.15	0.28	0.01	0.44

	FUD	Status	MUE	Modifiers				IOM Reference
90471	N/A	A	1(2)	N/A	N/A	N/A	80*	None
90472	N/A	A	8(3)	N/A	N/A	N/A	80*	

* with documentation

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

These codes are reported only once regardless of the number of nails that are 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
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
L62	Nail disorders in diseases classified elsewhere

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0127	0.17	0.54	0.01	0.72
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

nail. Thin, horny plate on the dorsal side of the phalanx of the distal toes and fingers.

G0136

G0136 Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes

Explanation

A physician or other qualified health care professional administers an assessment of an individual's social determinants of health (SDOH) or identified social risk factors that may influence the diagnosis and treatment of medical conditions. SDOH can limit the provider's ability to diagnose or treat a condition and the patient's ability to follow the prescribed treatment plan. This service is reported in addition to an E/M service or the annual wellness visit (AWV). This service may only be reported once every six months. This service is approved by Medicare as a telehealth service and may be performed by staff under incident-to guidelines.

Coding Tips

Medicare has identified this code as a telehealth/telemedicine service. Telemedicine services may be reported by the performing provider by using the appropriate place-of-service (POS) indicator. This service may be provided in addition to an annual wellness visit (AWV); outpatient E/M service 99202-99205, 99212-99215; psychiatric diagnostic evaluation 90791; health behavior assessment and intervention service 96156, 96158, 96159, 96164, 96165, 96167, and 96168; or hospital discharge service.

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.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0136	0.18	0.38	0.01	0.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0136	0.18	0.08	0.01	0.27

	FUD	Status	MUE	Modifiers				IOM Reference
G0136	N/A	A	-	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

assessment. Process of reviewing a patient's health status, including collecting and studying information and data such as test values, signs, and symptoms.

SDOH. Social determinants of health.

social determinants of health. Socioeconomic factors that can affect a person's health, including both environmental and societal conditions such as education and literacy, employment, health behaviors, housing, lack of adequate food or water, occupational exposure to risk factors, social support, transportation, and violence. Tracking social needs that impact patients allows providers to identify population health trends and to promote the personalized care that addresses the medical and social needs of individual patients.