Podiatry

A comprehensive illustrated guide to coding and reimbursement

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Contents

Getting Started with Coding Companion

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

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

CPT Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

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

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

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

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

CCI Edit Updates

The *Coding Companion* series 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 the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2021 edition password is: XXXXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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:

69501   Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
    Transmastoid, 69501

Excision
    Mastoid
        Simple, 69501

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 xiii 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.
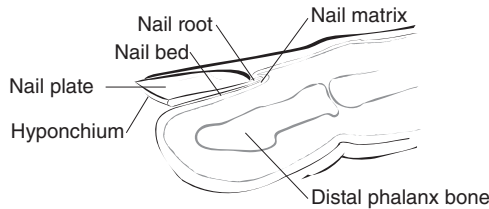
Professional and Technical Component

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.

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

10061 complicated or multiple

A small incision is made todrain an abscess or cyst

Explanation

The physician makes a small incision through the skin overlying an abscess for incision and drainage (e.g., carbuncle, cyst, furuncle, paronychia, hidradenitis). The abscess or cyst is opened with a surgical instrument, allowing the contents to drain. The lesion may be curetted and irrigated. The physician leaves the surgical wound open to allow for continued drainage or the physician may place a Penrose latex drain or gauze strip packing to allow continued drainage. Report 10060 for incision and drainage of a simple or single abscess. Report 10061 for complex or multiple cysts. Complex or multiple cysts may require surgical closure at a later date.

Coding Tips

Local anesthesia is included in these services. For incision and drainage of a subfascial soft tissue abscess, see the appropriate incision and drainage for specific anatomical sites. For biopsy of skin, see 11102, 11104, or 11106. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For puncture aspiration of an abscess, hematoma, bulla, or cyst, see 10160.

ICD-10-CM Diagnostic Codes

L02.415	Cutaneous abscess of right lower limb ☑
L02.416	Cutaneous abscess of left lower limb ☑
L02.425	Furuncle of right lower limb ☑
L02.426	Furuncle of left lower limb ☑
L02.435	Carbuncle of right lower limb ☑
L02.436	Carbuncle of left lower limb ☑
L02.611	Cutaneous abscess of right foot ☑
L02.612	Cutaneous abscess of left foot ☑
L02.621	Furuncle of right foot ☑
L02.622	Furuncle of left foot ☑
L02.631	Carbuncle of right foot ☑
L02.632	Carbuncle of left foot ☑
L02.818	Cutaneous abscess of other sites
L02.828	Furuncle of other sites
L02.838	Carbuncle of other sites
L03.031	Cellulitis of right toe ☑
L03.032	Cellulitis of left toe ☑
L03.042	Acute lymphangitis of left toe ☑
L03.115	Cellulitis of right lower limb ☑
L03.116	Cellulitis of left lower limb ☑
L03.818	Cellulitis of other sites
L08.0	Pyoderma
L08.89	Other specified local infections of the skin and subcutaneous tissue
L98.0	Pyogenic granuloma

AMA: 10060 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11 **10061** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
10060	1.22	2.09	0.13	3.44
10061	2.45	3.2	0.32	5.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
10060	1.22	1.52	0.13	2.87
10061	2.45	2.44	0.32	5.21

	FUD	Status	MUE	Modifiers				IOM Reference
10060	10	A	1(2)	51	N/A	N/A	N/A	None
10061	10	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
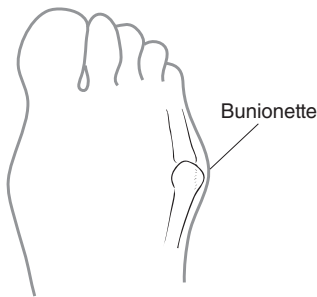
cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

furuncle. Inflamed, painful abscess, cyst, or nodule on the skin caused by bacteria, often Staphylococcus, entering along the hair follicle.
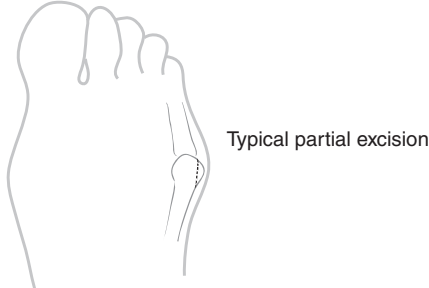
paronychia. Infection or cellulitis of nail structures.

28110

28110 Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

A bunionette occurs on the head of the fifth metatarsal

Typical partial excision

Explanation

The physician makes a lateral incision over the distal third of the fifth metatarsal bone to expose the metatarsal head. An osteotome is used to remove the lateral extension of the bone (bunionette). The cut is made along the shaft of the bone. The wound is irrigated and the soft tissues are sutured. Soft dressing is applied and weight bearing is allowed as tolerated.

Coding Tips

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

ICD-10-CM Diagnostic Codes

M21.621	Bunionette of right foot ☑
M21.622	Bunionette of left foot ☑
M21.6X1	Other acquired deformities of right foot ☑
M21.6X2	Other acquired deformities of left foot ☑
M25.774	Osteophyte, right foot ☑
M25.775	Osteophyte, left foot ☑
M84.871	Other disorders of continuity of bone, right ankle and foot ☑
M84.872	Other disorders of continuity of bone, left ankle and foot ☑
M89.371	Hypertrophy of bone, right ankle and foot ☑
M89.372	Hypertrophy of bone, left ankle and foot ☑
M89.8X7	Other specified disorders of bone, ankle and foot

Q66.211	Congenital metatarsus primus varus, right foot ☑
Q66.212	Congenital metatarsus primus varus, left foot ☑
Q66.221	Congenital metatarsus adductus, right foot ☑
Q66.222	Congenital metatarsus adductus, left foot ☑

AMA: 28110 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28110	4.22	8.71	0.43	13.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
28110	4.22	3.7	0.43	8.35

	FUD	Status	MUE	Modifiers				IOM Reference
28110	90	A	1(2)	51	50	62*	N/A	None

* with documentation

Terms To Know

bunion. Displacement of the first metatarsal bone outward with a simultaneous displacement of the great toe away from the midline toward the smaller toes. This causes a bony prominence of the joint of the great toe on the inside (medial) margin of the forefoot, termed a bunion.

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

exostosis. Abnormal formation of a benign bony growth.

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

ostectomy. Excision of bone.

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.

Foot and Toes

99000

99000 Handling and/or conveyance of specimen for transfer from the office to a laboratory

Explanation

This code is adjunct to basic services rendered. This code is reported for the handling and/or conveyance of a specimen from the provider's office to a laboratory.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99000	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99000	0.0	0.0	0.0	0.0

99001

99001 Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)

Explanation

This code is adjunct to basic services rendered. This code is reported for the handling and/or conveyance of a specimen from the patient in a location other than the provider's office to the laboratory.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99001	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99001	0.0	0.0	0.0	0.0

99002

99002 Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician or other qualified health care professional

Explanation

This code is adjunct to basic services rendered. The qualified provider reports this code for the handling, conveyance, and/or any other service in connection with the implementation of an order involving devices such as orthotics, protectives, and prosthetics fabricated by an outside laboratory and fitted by the provider.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99002	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99002	0.0	0.0	0.0	0.0

99024

99024 Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure

Explanation

The physician reports this code to indicate a postoperative follow-up visit, normally included in the surgical package when the physician performs an evaluation and management service for reason(s) that are related to the original procedure.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99024	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99024	0.0	0.0	0.0	0.0

99026-99027

99026 Hospital mandated on call service; in-hospital, each hour
99027 out-of-hospital, each hour

Explanation

The code reports the time for hospital mandated on call service provided by the physician. This code does not include prolonged physician attendance time for standby services or the time spent performing other reportable procedures or services. Report 99026 for each hour of hospital mandated on call service spent in the hospital and 99027 for each hour of hospital mandated on call service spent outside the hospital.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99026	0.0	0.0	0.0	0.0
99027	0.0	0.0	0.0	0.0

99050

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services after posted office hours in addition to basic services.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99050	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99050	0.0	0.0	0.0	0.0

99051

99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

Explanation

This code is adjunct to basic services rendered. The physician reports this code to indicate services provided during posted evening, weekend, or holiday office hours in addition to basic services.

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