OPTUM360®

CODING COMPANION

# Podiatry

## A comprehensive illustrated guide to coding and reimbursement



**2021**

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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 version XX.X, 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 2022 edition password is: **XXXXXX22**. 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 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.

# 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. Usually, the presenting problem(s) are minimal.

▲★**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 in which the presenting problems are typically minimal and 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 CPT revised 2021 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. Medicare has identified 99211 as a telehealth/telemedicine service. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. 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.

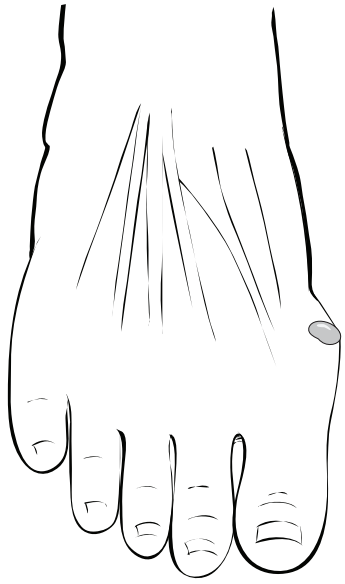
**AMA:** **99211** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Mar,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Mar,13; 2014,Jan,11; 2014,Aug,3 **99212** 2020,Sep,14; 2020,Sep,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,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99213** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99214** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99215** 2020,Sep,3; 2020,Sep,14; 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,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3



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

# 11420-11426

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



Excision of a benign lesion of the foot

## Explanation

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

## Coding Tips

Excision of a benign lesion requires a full-thickness incision and removal of the lesion and tissue margins. Local anesthesia is included in these services. These procedures include simple (non-layered) repair of the skin and/or subcutaneous tissues. If intermediate repair involving layered closure of deeper subcutaneous or nonmuscle fascia is required, it is reported separately. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For shaving of an epidermal or a dermal lesion, see 11300–11303. For destruction of a lesion by electrosurgical or other methods, see 17000 et seq. For excision of a malignant lesion, see 11600–11606. For handling or conveyance of a specimen transported to an outside laboratory, see 99000.

## ICD-10-CM Diagnostic Codes

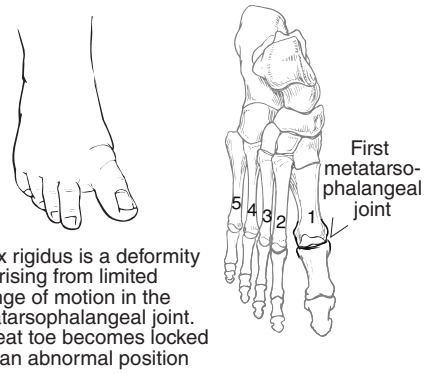
D17.23 Benign lipomatous neoplasm of skin and subcutaneous tissue of right leg ☑
D17.24 Benign lipomatous neoplasm of skin and subcutaneous tissue of left leg ☑
D18.01 Hemangioma of skin and subcutaneous tissue
D22.71 Melanocytic nevi of right lower limb, including hip ☑
D22.72 Melanocytic nevi of left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

**AMA:** **11420** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,12; 2014,Mar,4; 2014,Jan,11
**11421** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,4; 2014,Mar,12; 2014,Jan,11
**11422** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,4; 2014,Mar,12; 2014,Jan,11
**11423** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,12; 2014,Mar,4; 2014,Jan,11
**11424** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,12; 2014,Mar,4; 2014,Jan,11
**11426** 2019,Nov,3; 2018,Sep,7; 2018,Jan,8; 2018,Feb,10; 2017,Jan,8; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Mar,12; 2014,Mar,4; 2014,Jan,11

# 28289-28291

**28289** Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant

**28291** with implant




Hallux rigidus is a deformity arising from limited range of motion in the metatarsophalangeal joint. The great toe becomes locked into an abnormal position

## Explanation

The physician corrects a hallux rigidus deformity and performs a cheilectomy. Hallux rigidus is a condition caused by degenerative (DJD) arthritic changes at the first metatarsophalangeal joint, causing pain, limited range of motion, and dorsiflexion. In the context of this procedure, a cheilectomy refers to excision of part of the lip of the first metatarsophalangeal joint. The podiatrist makes a dorsal incision over the first metatarsophalangeal joint. The extensor hallucis longus tendon is retracted and the joint capsule is entered. Osteophytes and part of the metatarsal head are excised. Bony irregularities may be removed using a chisel and edges smoothed with a rasp. When adequate dorsiflexion (60 to 80 degrees) is obtained, the capsule is closed, the tendon is returned to its correct anatomical position, and the skin is closed with sutures. Report 28291 when the procedure includes an implant.

## Coding Tips

For treatment of arthritic changes involving partial ostectomy, exostectomy, or condylectomy of the metatarsophalangeal head only, see 28288. For radiology services, see 73620–73660.

## ICD-10-CM Diagnostic Codes

M20.21 Hallux rigidus, right foot ☑

M20.22 Hallux rigidus, left foot ☑

**AMA:** **28289** 2020,Jul,13; 2020,Aug,14; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Dec,3; 2015,Sep,12; 2015,Jan,16; 2014,Jan,11 **28291** 2020,Aug,14; 2018,Jan,8; 2017,Nov,10; 2017,Jan,8; 2016,Dec,3

## Relative Value Units/Medicare Edits

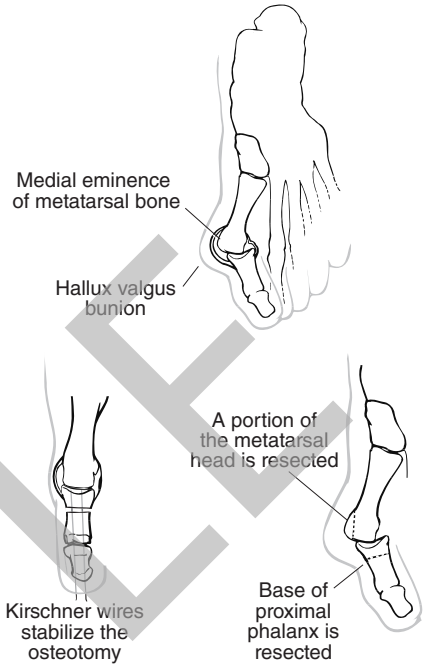
| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **28289** | 6.9 | 12.91 | 0.78 | 20.59 |
| **28291** | 8.01 | 12.29 | 0.76 | 21.06 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **28289** | 6.9 | 5.54 | 0.78 | 13.22 |
| **28291** | 8.01 | 5.34 | 0.76 | 14.11 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **28289** | 90 | A | 1(2) | 51 | 50 | 62* | 80 | None |
| **28291** | 90 | A | 1(2) | 51 | 50 | 62* | 80 | |

* with documentation

# 28292

**28292** Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method




## Explanation

The physician surgically corrects a bunion of the foot by any method (Keller, McBride, Mayo, etc.). The physician makes an incision along the medial aspect (inside) of the big toe. The incision is carried deep to the metatarsophalangeal joint. In a Keller procedure, the median eminence and one-third of the base of the proximal phalanx are resected. This is followed by repair of the plantar plate and stabilization with a longitudinal K-wire. In a McBride procedure, the adductor tendon and transverse metatarsal ligament are released through an incision made between the first and second toe. Following the release of the contractured lateral structures, the subluxated first MP joint is reduced and the median eminence is excised. The medial capsule of the first MP joint is imbricated through a medial arthrotomy incision. In a Mayo procedure, the first metatarsal head and its articular cartilage are removed and the remaining bone is restructured. Excision of a medial exostosis is performed. The external joint capsule is configured so that it can be used as cartilage between the metatarsal bone and the base of the first proximal phalanx. Fixation devices may hold the bone fragments in position. The procedure includes a sesamoidectomy and resection of the proximal phalanx base, when performed. The wound is closed in layers after thorough irrigation.

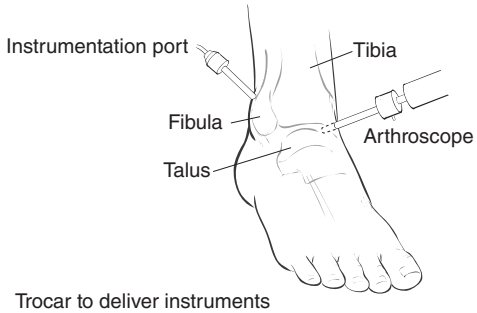
## Coding Tips

To correct severe hallux valgus deformities, this procedure may be used in combination with other techniques. When used in combination with other methods (e.g., double osteotomy), see 28299. 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 radiology services, see 73620–73660.

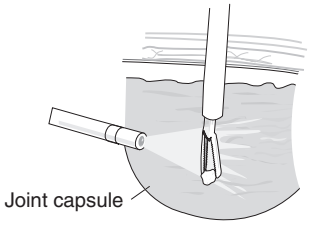
# 29897-29898

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

**29898** debridement, extensive




Trocar to deliver instruments




Schematic of removal of debris from capsule

## Explanation

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

## Coding Tips

Surgical arthroscopy includes a diagnostic arthroscopy. CPT guidelines indicate that when the physician cannot complete the procedure through the arthroscope and an open procedure is performed, list the open procedure first, code the arthroscope as diagnostic, and append modifier 51. Medicare and some other third-party payers do not allow a scope procedure when performed in conjunction with a related open procedure. Check with individual payers regarding their specific coding guidelines. According to CPT guidelines, 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 the Musculoskeletal System. For a radiology exam of the ankle, see 73600–73615.

## ICD-10-CM Diagnostic Codes

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

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

M06.271 Rheumatoid bursitis, right ankle and foot ☑

M06.371 Rheumatoid nodule, right ankle and foot ☑

M07.671 Enteropathic arthropathies, right ankle and foot ☑

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

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

**AMA:** **29897** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **29898** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **29897** | 7.32 | 5.96 | 1.13 | 14.41 |
| **29898** | 8.49 | 6.51 | 1.24 | 16.24 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **29897** | 7.32 | 5.96 | 1.13 | 14.41 |
| **29898** | 8.49 | 6.51 | 1.24 | 16.24 |

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

* with documentation

## Terms To Know

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

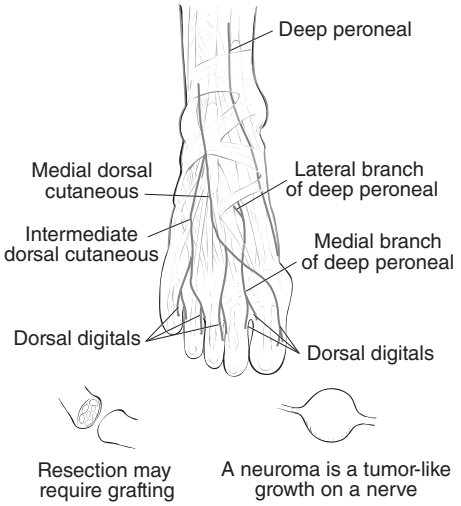
**debridement.** Removal of dead or contaminated tissue and foreign matter from a wound.

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

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

# 64774-64778

**64774** Excision of neuroma; cutaneous nerve, surgically identifiable
**64776** digital nerve, 1 or both, same digit
**+ 64778** digital nerve, each additional digit (List separately in addition to code for primary procedure)




A neuroma is excised

## Explanation

The physician excises a neuroma of a peripheral nerve. A neuroma is a benign tumor formed secondarily by trauma to the nerve. In 64774, the physician incises the skin and locates and excises the neuroma in the subcutaneous tissue. In 64776, the physician incises the skin over the digital nerve and excises the neuroma. Report 64778 for each additional neuroma of a separate digit.

## Coding Tips

Report 64776 and 64778 only once for each toe even if both digital nerves are released. Report 64778 in addition to 64776 when multiple digits are involved. When nerve end is implanted into bone or muscle, report 64787 in addition to the neuroma excision. For excision of a Morton's neuroma, see 28080.

## ICD-10-CM Diagnostic Codes

| | |
|---|---|
| D36.13 | Benign neoplasm of peripheral nerves and autonomic nervous system of lower limb, including hip |
| D36.16 | Benign neoplasm of peripheral nerves and autonomic nervous system of pelvis |
| G58.8 | Other specified mononeuropathies |
| M79.604 | Pain in right leg ☑ |
| M79.605 | Pain in left leg ☑ |
| M79.661 | Pain in right lower leg ☑ |
| M79.662 | Pain in left lower leg ☑ |
| M79.671 | Pain in right foot ☑ |
| M79.672 | Pain in left foot ☑ |
| T87.33 | Neuroma of amputation stump, right lower extremity ☑ |
| T87.34 | Neuroma of amputation stump, left lower extremity ☑ |

**AMA:** **64774** 2014,Jan,11 **64776** 2014,Jan,11 **64778** 2014,Jan,11

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| **64774** | 5.8 | 5.05 | 0.96 | 11.81 |
| **64776** | 5.6 | 4.81 | 0.82 | 11.23 |
| **64778** | 3.11 | 1.56 | 0.62 | 5.29 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| **64774** | 5.8 | 5.05 | 0.96 | 11.81 |
| **64776** | 5.6 | 4.81 | 0.82 | 11.23 |
| **64778** | 3.11 | 1.56 | 0.62 | 5.29 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| **64774** | 90 | A | 2(3) | 51 | N/A | N/A | N/A | None |
| **64776** | 90 | A | 1(2) | 51 | N/A | N/A | 80* | |
| **64778** | N/A | A | 1(3) | N/A | N/A | N/A | N/A | |

* with documentation

## Terms To Know

**cutaneous.** Relating to the skin.

**excision.** Surgical removal of an organ or tissue.

**incision.** Act of cutting into tissue or an organ.

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





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

# G0127

**G0127** Trimming of dystrophic nails, any number

## Explanation

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

## Coding Tips

This procedure is reported only once regardless of the number of nails trimmed. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided.

## ICD-10-CM Diagnostic Codes

B35.1 Tinea unguium
B37.2 Candidiasis of skin and nail
L03.031 Cellulitis of right toe ☑
L03.032 Cellulitis of left toe ☑
L03.041 Acute lymphangitis of right toe ☑
L03.042 Acute lymphangitis of left toe ☑
L60.0 Ingrowing nail
L60.1 Onycholysis
L60.2 Onychogryphosis
L60.3 Nail dystrophy
L60.4 Beau's lines
L60.5 Yellow nail syndrome
L60.8 Other nail disorders
R68.3 Clubbing of fingers

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| G0127 | 0.17 | 0.49 | 0.01 | 0.67 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| G0127 | 0.17 | 0.04 | 0.01 | 0.22 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|---|---|---|---|---|---|---|---|---|
| G0127 | 0 | R | 1(2) | 51 | N/A | N/A | N/A | None |

* with documentation

## Terms To Know

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

**paronychia.** Infection or cellulitis of nail structures.

# G0168

**G0168** Wound closure utilizing tissue adhesive(s) only

## Explanation

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

## Coding Tips

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

## ICD-10-CM Diagnostic Codes

S81.811A Laceration without foreign body, right lower leg, initial encounter ☑
S91.011A Laceration without foreign body, right ankle, initial encounter ☑
S91.111A Laceration without foreign body of right great toe without damage to nail, initial encounter ☑
S91.114A Laceration without foreign body of right lesser toe(s) without damage to nail, initial encounter ☑
S91.211A Laceration without foreign body of right great toe with damage to nail, initial encounter ☑
S91.214A Laceration without foreign body of right lesser toe(s) with damage to nail, initial encounter ☑
S91.311A Laceration without foreign body, right foot, initial encounter ☑

## Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| G0168 | 0.31 | 2.66 | 0.06 | 3.03 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| G0168 | 0.31 | 0.17 | 0.06 | 0.54 |

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

* with documentation

## Terms To Know

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

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 73660 | 0.13 | 0.64 | 0.02 | 0.79 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 73660 | 0.13 | 0.64 | 0.02 | 0.79 |

## 76080

**76080** Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation

### Explanation

An injection of radiopaque material is made directly into a sinus tract (a canal or passage leading to an abscess) or through a previously placed catheter, to determine the existence, nature, or size of an abscess or fistula (an abnormal tube-like passage from a normal body cavity to a free surface or to another body cavity). This code reports the radiological supervision and interpretation only.

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 76080 | 0.54 | 1.09 | 0.04 | 1.67 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 76080 | 0.54 | 1.09 | 0.04 | 1.67 |

## 76881-76882

**76881** Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation

**76882** Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation

### Explanation

Diagnostic ultrasound is an imaging technique that bounces soundwaves far above the level of human perception through interior body structures. The soundwaves pass through different tissue densities and reflect back to a receiving unit at varying speeds. The unit converts the waves to electrical pulses that are immediately displayed in picture form on a screen. Real time scanning displays structure images and movement in real time. In 76881, ultrasonography of a complete joint (e.g., joint space, muscles, tendons, and other periarticular soft tissue structures) is performed. Report 76882 for a limited study of a joint or other nonvascular extremity (e.g., joint space, muscle(s), nerve(s), periarticular tendon(s), soft tissue mass, or other soft tissue structure). Imaging documentation is included in these services.

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 76881 | 0.63 | 1.53 | 0.03 | 2.19 |
| 76882 | 0.49 | 1.09 | 0.03 | 1.61 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 76881 | 0.63 | 1.53 | 0.03 | 2.19 |
| 76882 | 0.49 | 1.09 | 0.03 | 1.61 |

## 76942

**76942** Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

### Explanation

Ultrasonic guidance is used for guiding needle placement required for procedures such as breast biopsies, needle aspirations, injections, or placing localizing devices. Ultrasound is the process of bouncing sound waves far above the level of human perception through interior body structures. The sound waves pass through different densities of tissue and reflect back to a receiving unit at varying speeds. The unit converts the waves to electrical pulses that are immediately displayed in picture form on screen. Once the exact needle entry site is determined along with the depth of the lesion, the optimal route from the skin to the lesion is decided. The needle is inserted and advanced to the lesion under ultrasonic guidance. This code reports the imaging supervision and interpretation only for this procedure.

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 76942 | 0.67 | 0.91 | 0.04 | 1.62 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 76942 | 0.67 | 0.91 | 0.04 | 1.62 |

## 76998

**76998** Ultrasonic guidance, intraoperative

### Explanation

Ultrasonography is used during a procedure to guide the physician in successfully accomplishing the surgery. Ultrasonic guidance may be used by the physician intraoperatively during many different types of operations on various areas of the body. Examples of intraoperative ultrasonic guidance include evaluating tissue removal in anatomical structures such as the breast, brain, abdominal organs, etc. This procedure may also be used to determine the location and depth of incisions to be made. This code is not to be used for ultrasound guidance for open or laparoscopic radiofrequency tissue ablation.

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 76998 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 76998 | 0.0 | 0.0 | 0.0 | 0.0 |

## 77002

**+ 77002** Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

### Explanation

Fluoroscopic guidance produces x-ray images shown on a screen to assist in visualization of the anatomy, instrument insertion, and/or contrast. This code is specifically reported when utilized for needle biopsy or fine needle aspiration. A cutting biopsy or fine needle is inserted into the target area and the position reaffirmed by fluoroscopy. This is done for an internal mass or lesion that has been positively identified by other diagnostic imaging performed earlier.

### Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|---|---|---|---|---|
| 77002 | 0.54 | 2.47 | 0.04 | 3.05 |
| **Facility RVU** | **Work** | **PE** | **MP** | **Total** |
| 77002 | 0.54 | 2.47 | 0.04 | 3.05 |

# CPT Index









● New ▲ Revised + Add On AMA: CPT Assist[Resequenced]