OPTUM360®

CODING COMPANION

Orthopaedics: Lower - Hips & Below

A comprehensive illustrated guide to coding and reimbursement

2022

optum360coding.com

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Getting Started with Coding Companion

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

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

CPT Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

Overall, 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 page following the sample.

Appendix Codes and Descriptions

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

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

- HCPCS
- 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: **XXXXXXX22**. 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.

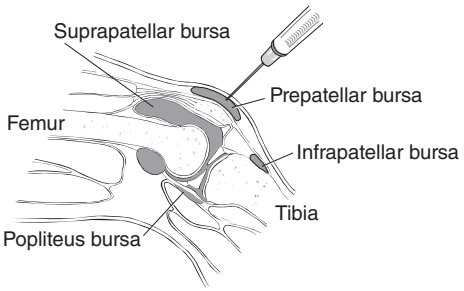
AMA: **99211** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Mar,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3;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

20610-20611

20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance

20611 with ultrasound guidance, with permanent recording and reporting



Explanation

After administering a local anesthetic, the physician inserts a needle through the skin and into a joint or bursa. A fluid sample may be removed from the joint for examination or a fluid may be injected for lavage or drug therapy. The needle is then withdrawn and pressure is applied to stop any bleeding. Report 20610 for a major joint or bursa injection or aspiration, such as of the shoulder, hip, knee joint, or subacromial bursa, without ultrasound guidance; 20611 for a major joint or bursa, with ultrasound guidance, including permanent record and report.

Coding Tips

Code selection depends on the size of the joint and whether the procedure was performed with or without ultrasonic guidance. If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, and 77021. Do not report 20610–20611 with 27369 or 76942. When more than one procedure is performed on the same joint, do not report separately. For aspiration or injection of a ganglion cyst, any location, see 20612. For injection of autologous, adipose-derived regenerative cells, see 0489T-0490T.

ICD-10-CM Diagnostic Codes

M00.851 Arthritis due to other bacteria, right hip ☑
M00.861 Arthritis due to other bacteria, right knee ☑
M05.251 Rheumatoid vasculitis with rheumatoid arthritis of right hip ☑
M05.261 Rheumatoid vasculitis with rheumatoid arthritis of right knee ☑
M05.751 Rheumatoid arthritis with rheumatoid factor of right hip without organ or systems involvement ☑
M05.761 Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement ☑
M06.051 Rheumatoid arthritis without rheumatoid factor, right hip ☑
M06.061 Rheumatoid arthritis without rheumatoid factor, right knee ☑
M06.251 Rheumatoid bursitis, right hip ☑
M06.261 Rheumatoid bursitis, right knee ☑
M07.651 Enteropathic arthropathies, right hip ☑
M07.661 Enteropathic arthropathies, right knee ☑
M10.051 Idiopathic gout, right hip ☑
M10.061 Idiopathic gout, right knee ☑
M11.851 Other specified crystal arthropathies, right hip ☑
M11.861 Other specified crystal arthropathies, right knee ☑
M12.551 Traumatic arthropathy, right hip ☑
M12.561 Traumatic arthropathy, right knee ☑
M16.51 Unilateral post-traumatic osteoarthritis, right hip ☑
M17.31 Unilateral post-traumatic osteoarthritis, right knee ☑
M23.8X1 Other internal derangements of right knee ☑
M25.051 Hemarthrosis, right hip ☑
M25.061 Hemarthrosis, right knee ☑
M25.451 Effusion, right hip ☑
M25.461 Effusion, right knee ☑
M65.151 Other infective (teno)synovitis, right hip ☑
M65.161 Other infective (teno)synovitis, right knee ☑
M70.41 Prepatellar bursitis, right knee ☑
M70.61 Trochanteric bursitis, right hip ☑

AMA: **20610** 2019,Aug,7; 2018,Jan,8; 2017,Jan,8; 2017,Apr,9; 2016,Jan,13; 2015,Nov,10; 2015,Jan,16; 2015,Feb,6; 2015,Aug,6; 2014,Jan,11; 2014,Dec,18
20611 2019,Aug,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Nov,10; 2015,Jul,10; 2015,Feb,6; 2015,Aug,6

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20610	0.79	0.86	0.12	1.77
20611	1.1	1.45	0.13	2.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
20610	0.79	0.41	0.12	1.32
20611	1.1	0.5	0.13	1.73

	FUD	Status	MUE	Modifiers				IOM Reference
20610	0	A	2(3)	51	50	N/A	N/A	None
20611	0	A	2(3)	51	50	N/A	N/A	

* with documentation

Terms To Know

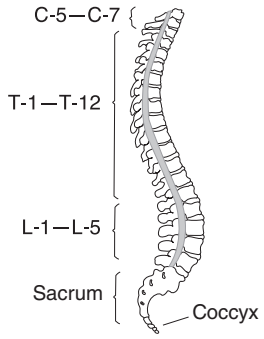
arthropathy. Disease of the joints.

aspiration. Drawing fluid out by suction.

bursitis. Inflammation of the fluid-filled cavity or sac that reduces friction between neighboring, moving parts.

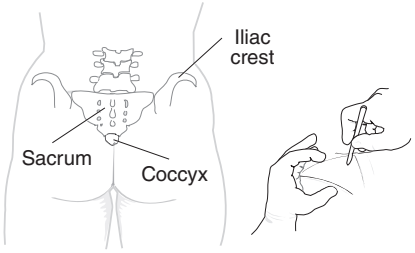
27202

27202 Open treatment of coccygeal fracture



The coccyx is informally known as the tailbone

A coccygeal fracture is treated in an open surgical session



Explanation

The patient is positioned prone. The physician makes a vertical incision in the gluteal fold. Dissection is carried down to the coccyx. The fractured portion is removed or internal fixation is applied. The incision is repaired in layers.

Coding Tips

Debridement of an open fracture is reported separately, see 11010–11012. For closed treatment of a coccygeal fracture, see 27200.

ICD-10-CM Diagnostic Codes

S32.2XXA Fracture of coccyx, initial encounter for closed fracture

S32.2XXB Fracture of coccyx, initial encounter for open fracture

S32.2XXK Fracture of coccyx, subsequent encounter for fracture with nonunion

AMA: **27202** 2018,Sep,7

Relative Value Units/Medicare Edits

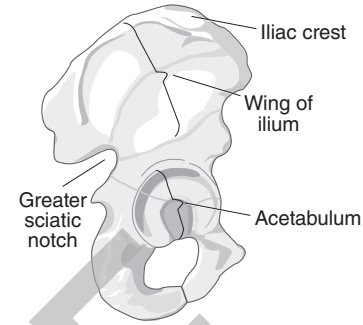
Non-Facility RVU	Work	PE	MP	Total
27202	7.31	6.54	1.44	15.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
27202	7.31	6.54	1.44	15.29

	FUD	Status	MUE	Modifiers				IOM Reference
27202	90	A	1(2)	51	N/A	N/A	80	None

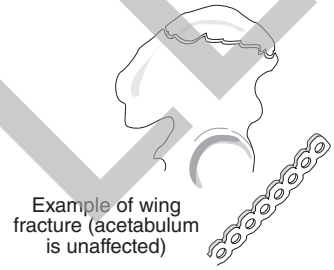
* with documentation

27215

27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed



Internal fixation (typically a plate with screws across the fracture) is applied



Example of wing fracture (acetabulum is unaffected)

Explanation

The physician performs open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s) by making an incision overlying the site of injury. Dissection exposes the avulsion and/or fracture. For an avulsion, a screw(s) is drilled through the bone fragment, reattaching the tendon and bone fragment to the original positions. The physician stabilizes an iliac wing fracture with a plate and screws across the fracture. The incision is repaired in layers. Suction drains may be applied. This code reports unilateral treatment for fracture patterns of the pelvic bone that do not disrupt the pelvic ring and includes internal fixation when performed.

Coding Tips

Debridement of an open fracture is reported separately, see 11010–11012. Any internal fixation is not reported separately. 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).For open treatment of a pelvic ring fracture, anterior, see 27217; posterior, see 27218.

ICD-10-CM Diagnostic Codes

M84.350A Stress fracture, pelvis, initial encounter for fracture

M84.454A Pathological fracture, pelvis, initial encounter for fracture

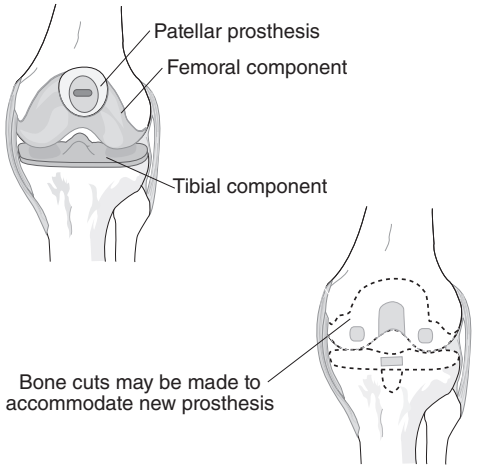
S32.311A Displaced avulsion fracture of right ilium, initial encounter for closed fracture ☑

S32.82XA Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for closed fracture

27486-27487

27486 Revision of total knee arthroplasty, with or without allograft; 1 component

27487 femoral and entire tibial component



Explanation

The physician performs a revision of a total knee arthroplasty. Typically, previous skin incisions are incorporated to expose the knee. In 27486, one of the femoral or tibial components or the polyethylene liner is removed as determined by the physician. In order to remove the components, an osteotome or saw may be used to loosen the cement or bone so that the prosthesis can be popped out with a mallet. If any cement is present, it is removed in order to protect and preserve as much bone as possible. Bone cuts are made to accommodate the new prosthesis. If significant bone defects are present on the femur, tibia, or both, a bone graft may be needed. An allograft (donor bone) may be packed into the defect. The components of the new prosthesis are placed into position and may be cemented for fixation. In 27487, the femoral and tibial components are both revised. The incision is repaired with sutures, staples, and/or Steri-strips.

Coding Tips

Any bone graft harvest is not reported separately. For initial knee arthroplasty, medial or lateral compartment, see 27446. For initial total knee replacement, which includes the medial and lateral compartments, see 27447. For removal of a knee prosthesis, see 27488.

ICD-10-CM Diagnostic Codes

M97.11XD Periprosthetic fracture around internal prosthetic right knee joint, subsequent encounter ☑

T84.012A Broken internal right knee prosthesis, initial encounter ☑

T84.013A Broken internal left knee prosthesis, initial encounter ☑

T84.022A Instability of internal right knee prosthesis, initial encounter ☑

T84.023A Instability of internal left knee prosthesis, initial encounter ☑

T84.028A Dislocation of other internal joint prosthesis, initial encounter

T84.032A Mechanical loosening of internal right knee prosthetic joint, initial encounter ☑

T84.033A Mechanical loosening of internal left knee prosthetic joint, initial encounter ☑

T84.052A Periprosthetic osteolysis of internal prosthetic right knee joint, initial encounter ☑

T84.053A Periprosthetic osteolysis of internal prosthetic left knee joint, initial encounter ☑

T84.062A Wear of articular bearing surface of internal prosthetic right knee joint, initial encounter ☑

T84.063A Wear of articular bearing surface of internal prosthetic left knee joint, initial encounter ☑

T84.092A Other mechanical complication of internal right knee prosthesis, initial encounter ☑

T84.093A Other mechanical complication of internal left knee prosthesis, initial encounter ☑

T84.53XA Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter ☑

T84.54XA Infection and inflammatory reaction due to internal left knee prosthesis, initial encounter ☑

T84.81XA Embolism due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.82XA Fibrosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.83XA Hemorrhage due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.84XA Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.85XA Stenosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.86XA Thrombosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

T84.89XA Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter

Z96.651 Presence of right artificial knee joint ☑

Z96.652 Presence of left artificial knee joint ☑

Z96.653 Presence of artificial knee joint, bilateral ☑

AMA: **27486** 2018,Sep,7; 2018,Jan,8; 2018,Apr,10; 2017,Jan,8; 2016,Jan,13; 2015,Jul,10; 2015,Jan,16; 2014,Jan,11 **27487** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27486	21.12	15.4	4.16	40.68
27487	27.11	18.42	5.35	50.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
27486	21.12	15.4	4.16	40.68
27487	27.11	18.42	5.35	50.88

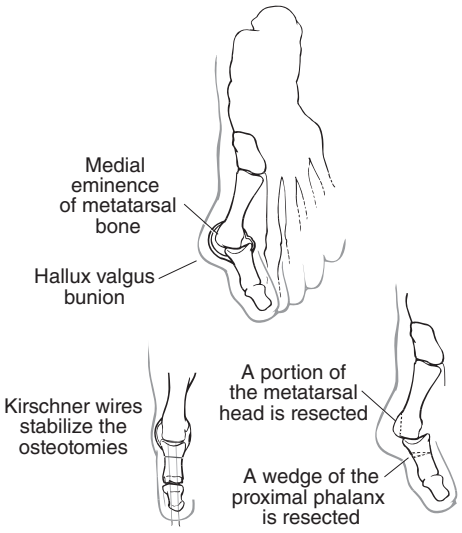
	FUD	Status	MUE	Modifiers				IOM Reference
27486	90	A	1(2)	51	50	62*	80	None
27487	90	A	1(2)	51	50	62*	80	

* with documentation

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

28299

28299 Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method



Explanation

The physician treats a severe hallux valgus (bunion) deformity of the foot by double osteotomy via any method. The physician makes an incision over the first metatarsal. Various methods of double osteotomy may be performed. In a distal Austin double osteotomy, the soft tissue is corrected and a V-osteotomy is made through the metatarsal head and neck that is displaced laterally to replace the metatarsal head over sesamoids. K wire fixation is used and a cast is applied.

Coding Tips

Procedures reported with this code include Swanson osteotomy and double osteotomy. Code 28299 should be reported only when the hallux valgus correction cannot be reported with a more specific code or when combined methods are used. For other, more specific techniques, see 28289–28298. 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.

ICD-10-CM Diagnostic Codes

M20.11 Hallux valgus (acquired), right foot ☑
M20.12 Hallux valgus (acquired), left foot ☑
M21.611 Bunion of right foot ☑
M21.612 Bunion of left foot ☑
M21.621 Bunionette of right foot ☑
M21.622 Bunionette of left foot ☑

AMA: **28299** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Dec,3; 2016,Apr,8; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28299	9.29	18.85	0.96	29.1
Facility RVU	**Work**	**PE**	**MP**	**Total**
28299	9.29	6.55	0.96	16.8

	FUD	Status	MUE	Modifiers				IOM Reference
28299	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

acquired. Produced by outside influences and not by genetics or birth defect.

alignment. Establishment of a straight line or harmonious relationship between structures.

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.

deformity. Irregularity or malformation of the body.

excise. Remove or cut out.

hallux valgus. Deformity in which the great toe deviates toward the other toes and may even be positioned over or under the second toe.

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

K-wires. Steel wires for skeletal fixation of fractured bones, inserted through soft tissue and bones.

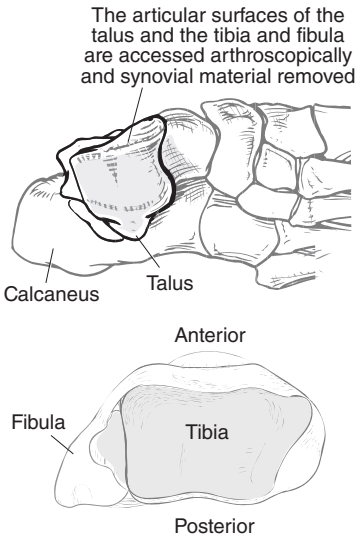
osteotomy. Surgical cutting of a bone.

soft tissue. Nonepithelial tissues outside of the skeleton.

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

29895

29895 Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial



Inferior view of the tibial and fibular articular surfaces

Explanation

The physician performs arthroscopy on an ankle joint to remove the synovial lining of the joint. With the patient soothed by general anesthesia, the physician makes two to four 0.5 cm skin incisions around the ankle. The physician introduces the arthroscope into the ankle and conducts an exam. The offending synovial tissue is identified. Additional instruments are placed through the incisions. Using the arthroscope, the physician uses these instruments to excise the synovium. The joint is irrigated and the skin portals 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 Musculoskeletal System. For arthrotomy, with synovectomy, see 27625; with tenosynovectomy, see 27626. For radiology services, see 73600–73615.

ICD-10-CM Diagnostic Codes

M05.471 Rheumatoid myopathy with rheumatoid arthritis of right ankle and foot ☑
M06.271 Rheumatoid bursitis, right ankle and foot ☑
M06.371 Rheumatoid nodule, right ankle and foot ☑
M12.271 Villonodular synovitis (pigmented), right ankle and foot ☑
M12.571 Traumatic arthropathy, right ankle and foot ☑
M19.071 Primary osteoarthritis, right ankle and foot ☑
M25.371 Other instability, right ankle ☑
M25.374 Other instability, right foot ☑
M25.671 Stiffness of right ankle, not elsewhere classified ☑
M25.674 Stiffness of right foot, not elsewhere classified ☑
S96.091A Other injury of muscle and tendon of long flexor muscle of toe at ankle and foot level, right foot, initial encounter ☑
S96.191A Other specified injury of muscle and tendon of long extensor muscle of toe at ankle and foot level, right foot, initial encounter ☑
S96.291A Other specified injury of intrinsic muscle and tendon at ankle and foot level, right foot, initial encounter ☑
S96.891A Other specified injury of other specified muscles and tendons at ankle and foot level, right foot, initial encounter ☑
S99.811A Other specified injuries of right ankle, initial encounter ☑
S99.821A Other specified injuries of right foot, initial encounter ☑

AMA: **29895** 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
29895	7.13	5.34	0.93	13.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
29895	7.13	5.34	0.93	13.4

	FUD	Status	MUE	Modifiers				IOM Reference
29895	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

bursitis. Inflammation of a bursa.

rheumatoid arthritis. Autoimmune disease causing pain, stiffness, inflammation, and possibly joint destruction.

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95860	0.96	2.38	0.06	3.4
95861	1.54	3.24	0.09	4.87
95863	1.87	4.06	0.09	6.02
95864	1.99	4.98	0.1	7.07
Facility RVU	**Work**	**PE**	**MP**	**Total**
95860	0.96	2.38	0.06	3.4
95861	1.54	3.24	0.09	4.87
95863	1.87	4.06	0.09	6.02
95864	1.99	4.98	0.1	7.07

95869-95870

95869 Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)

95870 limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters

Explanation

Needle electromyography (EMG) records the electrical properties of thoracic paraspinal muscles, excluding T1 or T12 (95869) using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. These codes are reported when there are no nerve conduction studies performed in conjunction with these procedures during the same day. Report 95870 for a limited study of muscles in one extremity or non-limb (axial) muscles other than thoracic paraspinal or cranial supplied muscles or sphincters.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95869	0.37	2.31	0.03	2.71
95870	0.37	2.16	0.03	2.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
95869	0.37	2.31	0.03	2.71
95870	0.37	2.16	0.03	2.56

95872

95872 Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. This procedure uses a single fiber electrode to obtain additional information on specific muscles, including quantitative measurement of jitter, blocking, and/or fiber density.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95872	2.88	2.64	0.14	5.66
Facility RVU	**Work**	**PE**	**MP**	**Total**
95872	2.88	2.64	0.14	5.66

[95885, 95886]

+ 95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

+ 95886 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. Report 95885 per limited study of an extremity and 95886 for a complete (five or more muscles) study of an extremity. Codes 95885-95886 can be reported for a total of four units if all extremities are tested.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95885	0.35	1.41	0.01	1.77
95886	0.86	1.86	0.03	2.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
95885	0.35	1.41	0.01	1.77
95886	0.86	1.86	0.03	2.75

[95887]

+ 95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. This code is specific to the 12 nerves that emerge from or enter the cranium or non-extremity muscles.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95887	0.71	1.66	0.03	2.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
95887	0.71	1.66	0.03	2.4

95875

95875 Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)

Explanation

This test is useful in the differential diagnosis of metabolic causes of muscle weakness, fatigue, and cramps (e.g., disorders of glycolysis and myoadenylate deaminase) and in the diagnosis of patients complaining of muscle cramps and exercise intolerance. After inflation of a sphygmomanometer (blood pressure) cuff, an intravenous cannula is inserted and a baseline blood sample is drawn from the occluded limb. The patient is exercised and the cuff may be inflated every few seconds for two minutes or the cuff is inflated until a predetermined reading is reached and the limb is then exercised for a specific timeframe. The

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