

Orthopaedics: Lower - Hips & Below

A comprehensive illustrated guide to
coding and reimbursement

SAMPLE

2025

optumcoding.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/HCPCS Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation.

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

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

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is <http://www.optumcoding.com/ProductUpdates/>. The 2025 edition password is: XXXXXX. Log in frequently to ensure you receive the most current updates.

Index

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

28285 Correction, hammertoe (eg, Interphalangeal fusion, partial or total phalangectomy)

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

Foot
Hammertoe Operation, 28285
or Hammertoe Repair, 28285-28286
or Reconstruction
Toe
Hammertoe, 28285-28286

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

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

Professional and Technical Component

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

Sample Page and Key

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

11055-11057

1

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



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

2

Explanation

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

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. Modifier Q7, Q8, or Q9 should be used to indicate a significant systemic condition (e.g., diabetes mellitus, peripheral neuropathies involving the feet) that puts the patient at risk for problems with wound healing and potential loss of limb. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

- G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective

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sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

AMA: 11055 2022, Feb 11056 2022, Feb 11057 2022, Feb

7

Relative Value Units/Medicare Edits

8

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 11055 | 0.35 | 1.76 | 0.04 | 2.15 |
| 11056 | 0.5 | 1.93 | 0.04 | 2.47 |
| 11057 | 0.65 | 2.0 | 0.04 | 2.69 |
| Facility RVU | Work | PE | MP | Total |
| 11055 | 0.35 | 0.08 | 0.04 | 0.47 |
| 11056 | 0.5 | 0.11 | 0.04 | 0.65 |
| 11057 | 0.65 | 0.15 | 0.04 | 0.84 |

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

*with documentation

Terms To Know

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

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

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

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

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

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

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

paring. Cutting away an edge or a surface.

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

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion*:

- This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- + This CPT code is an add-on code.

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

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

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

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

| | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|
| 90785 | 90791 | 90792 | 90832 | 90833 | 90834 | 90836 |
| 90837 | 90838 | 90839 | 90840 | 90845 | 90846 | 90847 |
| 92507 | 92508 | 92521 | 92522 | 92523 | 92524 | 96040 |
| 96110 | 96116 | 96121 | 96156 | 96158 | 96159 | 96160 |
| 96161 | 96164 | 96165 | 96167 | 96168 | 96170 | 96171 |
| 97802 | 97803 | 97804 | 99406 | 99407 | 99408 | 99409 |
| 99497 | 99498 | | | | | |

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding

guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

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

- ▢ Newborn: 0
- ▣ Pediatric: 0-17
- ▤ Maternity: 9-64
- ▥ Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at <https://www.optumcoding.com/ProductUpdates/>. The 2025 edition password is XXXXXX.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician

or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

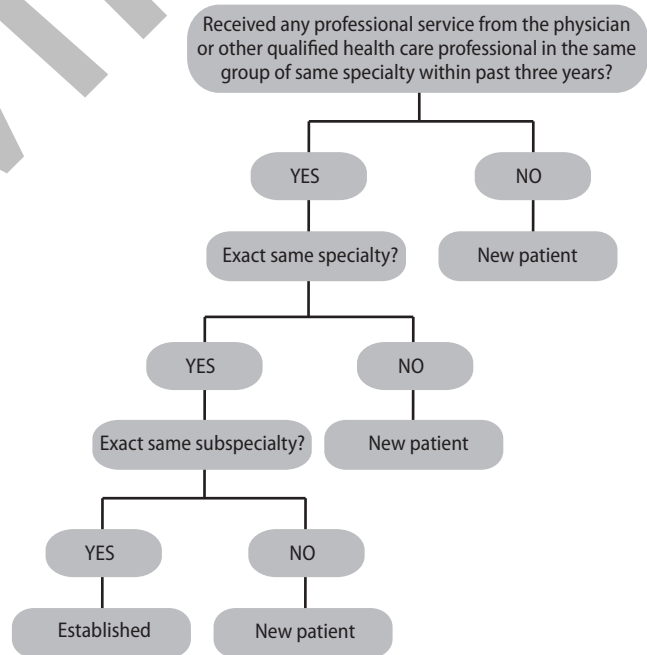
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

99202-99205

- ▲★99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- ▲★99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- ▲★99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- ▲★99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers

should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: 99202 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Mar; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 99202 | 0.93 | 1.14 | 0.08 | 2.15 |
| 99203 | 1.6 | 1.56 | 0.17 | 3.33 |
| 99204 | 2.6 | 2.11 | 0.23 | 4.94 |
| 99205 | 3.5 | 2.71 | 0.31 | 6.52 |
| Facility RVU | Work | PE | MP | Total |
| 99202 | 0.93 | 0.41 | 0.08 | 1.42 |
| 99203 | 1.6 | 0.68 | 0.17 | 2.45 |
| 99204 | 2.6 | 1.11 | 0.23 | 3.94 |
| 99205 | 3.5 | 1.54 | 0.31 | 5.35 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|-------|-----|--------|------|-----------|-----|-----|-----|--------------------|
| 99202 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | 100-04,11,40.1.3; |
| 99203 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | 100-04,12,30.6.4; |
| 99204 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | 100-04,12,30.6.10; |
| 99205 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | 100-04,12,190.7; |
| | | | | | | | | 100-04,12,230; |
| | | | | | | | | 100-04,12,230.1; |
| | | | | | | | | 100-04,18,80.2; |
| | | | | | | | | 100-04,32,12.1 |

* with documentation

15271-15274

- 15271** Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
- + **15272** each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
- 15273** Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
- + **15274** Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)



Explanation

The physician applies a skin substitute for temporary wound closure to a wound on the trunk or arms. Skin substitutes are used as a temporary measure to close wounds and provide a barrier against infection and fluid loss, reduce pain, and promote healing of underlying tissues until a permanent graft can be applied. Common skin substitutes include acellular dermal replacement, temporary allograft, acellular dermal allograft, tissue cultured allogenic skin substitute, and xenografts. The skin substitute is fashioned to fit the size and contours of the previously prepared wound bed on the trunk or arms. It is then placed over the wound and sutured or stapled into place. Report 15271 for the first 25 sq cm or less and 15272 for each additional 25 sq cm or less up to 100 sq cm. Report 15273 for the first 100 sq cm in adults or 1 percent of the total body surface area in infants and children. Report 15274 for each additional 100 sq cm in adults or 1 percent of the total body surface area in infants and children.

Coding Tips

Report 15272 in addition to 15271. If the total wound surface is greater than or equal to 100 sq cm, see 15273–15274. Report 15274 in addition to 15273. For adults and children 10 years of age or older, these codes should be reported using the sq cm criteria. For children younger than age 10, use percent of body surface area. Biological implant, 15777, may be reported separately when used in conjunction with this repair. Skin substitute may be reported with Q4100-Q4284 as appropriate. Check with the specific payer to determine coverage.

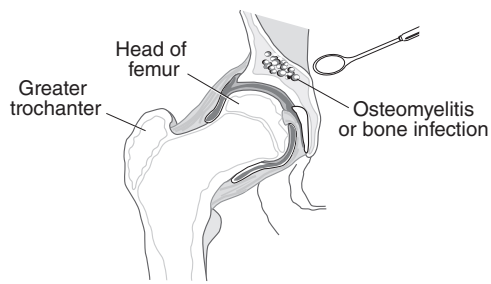
ICD-10-CM Diagnostic Codes

- I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle **A** **✓**
- I70.261 Atherosclerosis of native arteries of extremities with gangrene, right leg **A** **✓**
- I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle **A** **✓**
- I70.461 Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, right leg **A** **✓**
- I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle **A** **✓**
- I70.561 Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene, right leg **A** **✓**
- I83.013 Varicose veins of right lower extremity with ulcer of ankle **A** **✓**
- L97.315 Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis **✓**
- L97.316 Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis **✓**
- S81.811A Laceration without foreign body, right lower leg, initial encounter **✓**
- S81.821A Laceration with foreign body, right lower leg, initial encounter **✓**
- S81.831A Puncture wound without foreign body, right lower leg, initial encounter **✓**
- S81.841A Puncture wound with foreign body, right lower leg, initial encounter **✓**
- S91.011A Laceration without foreign body, right ankle, initial encounter **✓**
- S91.021A Laceration with foreign body, right ankle, initial encounter **✓**
- S91.031A Puncture wound without foreign body, right ankle, initial encounter **✓**
- S91.041A Puncture wound with foreign body, right ankle, initial encounter **✓**
- T81.33XA Disruption of traumatic injury wound repair, initial encounter
- T86.820 Skin graft (allograft) rejection
- T86.821 Skin graft (allograft) (autograft) failure
- T86.822 Skin graft (allograft) (autograft) infection
- T87.1X1 Complications of reattached (part of) right lower extremity **✓**
- T87.33 Neuroma of amputation stump, right lower extremity **✓**
- T87.43 Infection of amputation stump, right lower extremity **✓**
- T87.53 Necrosis of amputation stump, right lower extremity **✓**
- T87.81 Dehiscence of amputation stump

AMA: 15271 2022, Aug; 2022, Feb; 2021, Aug; 2017, Oct 15272 2022, Aug; 2022, Feb; 2021, Aug 15273 2022, Aug; 2022, Feb; 2021, Aug 15274 2022, Aug; 2022, Feb; 2021, Aug

26992

26992 Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)



Abscess is drained and dead bone tissue removed

Explanation

The physician incises the bone cortex of infected bone in the pelvis and/or hip joint to treat an abscess or osteomyelitis. The physician makes an incision over the affected area. Dissection is carried through the soft tissues to expose the bone. The periosteum is split and reflected from the bone overlying the infected area. A curette may be used to scrape away the abscess or infected portion to healthy bony tissue or drill holes may be made through the cortex into the medullary canal in a window outline around the infected or abscessed bone. The area is drained and debrided of infected bony and soft tissue. The physician irrigates the area with antibiotic solution, the periosteum is closed over the bone, and the soft tissues are sutured closed; or the wound is packed and left open, allowing the area to drain. Secondary closure is performed approximately three weeks later. Dressings are changed daily.

Coding Tips

Secondary closure, when necessary, of the surgical wound is reported separately, see 13160. When 26992 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For incision and drainage of a deep abscess or hematoma of the pelvis or hip joint area, see 26990; infected bursa, see 26991. For arthrotomy, hip, for infection, with drainage, see 27030. For incision and drainage procedures, superficial, see 10060-10061.

ICD-10-CM Diagnostic Codes

- M86.051 Acute hematogenous osteomyelitis, right femur ✓
- M86.052 Acute hematogenous osteomyelitis, left femur ✓
- M86.151 Other acute osteomyelitis, right femur ✓
- M86.152 Other acute osteomyelitis, left femur ✓
- M86.251 Subacute osteomyelitis, right femur ✓
- M86.252 Subacute osteomyelitis, left femur ✓
- M86.351 Chronic multifocal osteomyelitis, right femur ✓
- M86.352 Chronic multifocal osteomyelitis, left femur ✓
- M86.451 Chronic osteomyelitis with draining sinus, right femur ✓
- M86.452 Chronic osteomyelitis with draining sinus, left femur ✓
- M86.551 Other chronic hematogenous osteomyelitis, right femur ✓
- M86.552 Other chronic hematogenous osteomyelitis, left femur ✓
- M86.651 Other chronic osteomyelitis, right thigh ✓
- M86.652 Other chronic osteomyelitis, left thigh ✓
- M86.8X5 Other osteomyelitis, thigh

AMA: 26992 2023, Apr; 2021, Sep

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|-------|-------|------|-------|
| 26992 | 13.48 | 14.09 | 2.73 | 30.3 |
| Facility RVU | Work | PE | MP | Total |
| 26992 | 13.48 | 14.09 | 2.73 | 30.3 |

| | FUD | Status | MUE | Modifiers | | | IOM Reference | |
|--------------|-----|--------|------|-----------|-----|-----|---------------|------|
| 26992 | 90 | A | 2(3) | 51 | N/A | N/A | 80* | None |

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

acute. Sudden, severe. Documentation and reporting of an acute condition is important to establishing medical necessity.

chronic. Persistent, continuing, or recurring.

debride. To remove all foreign objects and devitalized or infected tissue from a burn or wound to prevent infection and promote healing.

dissection. Separating by cutting tissue or body structures apart.

incision. Act of cutting into tissue or an organ.

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

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

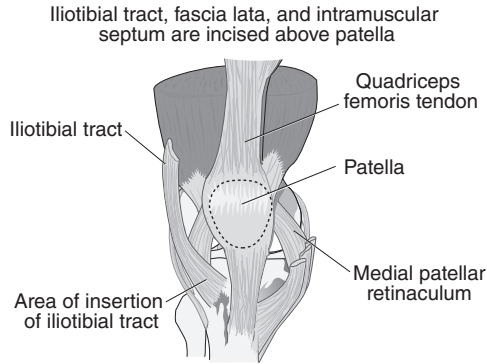
osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

periostitis. Inflammation of the outer layers 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.

27305

27305 Fasciotomy, iliotibial (tenotomy), open



Explanation

For release of the iliotibial band, the patient is placed in a lateral decubitus position. The physician exposes the iliotibial tract through a 4 cm lateral, longitudinal incision just above the femoral condyle. The physician incises the iliotibial tract, fascia lata, and intramuscular septum transversely 2.5 cm above the patella. In severe contractures, the physician may remove a segment of the iliotibial tract and septum. The incision is closed in layers with sutures, staples, and/or Steri-strips.

Coding Tips

This procedure is commonly performed for injuries. 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 a combined Ober Yount fasciotomy (fascia lata flap is transferred to erector spinae), see 27025. For decompression fasciotomy of the lower leg, see 27600–27602 and 27892–27894.

ICD-10-CM Diagnostic Codes

- M76.31 Iliotibial band syndrome, right leg
- M76.32 Iliotibial band syndrome, left leg
- M79.A21 Nontraumatic compartment syndrome of right lower extremity
- M79.A22 Nontraumatic compartment syndrome of left lower extremity
- T79.A21A Traumatic compartment syndrome of right lower extremity, initial encounter
- T79.A22A Traumatic compartment syndrome of left lower extremity, initial encounter

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 27305 | 6.18 | 7.26 | 1.21 | 14.65 |
| Facility RVU | Work | PE | MP | Total |
| 27305 | 6.18 | 7.26 | 1.21 | 14.65 |

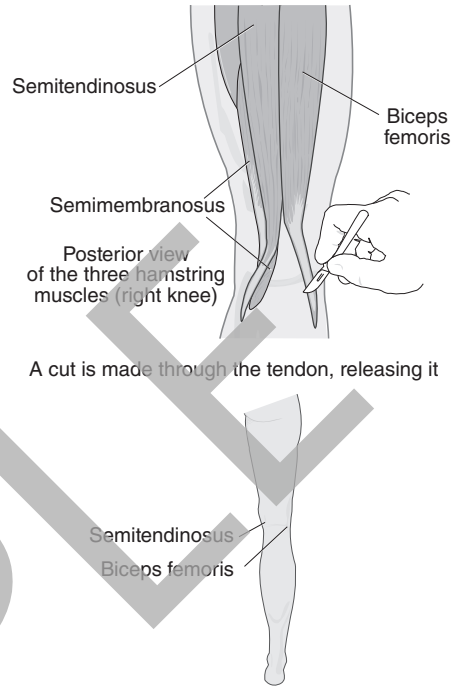
| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|--------------|-----|--------|------|-----------|----|-----|----|---------------|
| 27305 | 90 | A | 1(2) | 51 | 50 | 62* | 80 | None |

* with documentation

27306-27307

27306 Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)

27307 multiple tendons



Explanation

The physician performs a percutaneous tenotomy (cut) of the adductor or hamstring muscle. The physician palpates the tendon to be released. A small incision is made to access the tendon. The physician's thumb presses on the tendon to create tension. The physician uses an 11-blade to make a cut through the tendon, releasing it. More than one tendon is released in 27307. The incision is closed with sutures.

Coding Tips

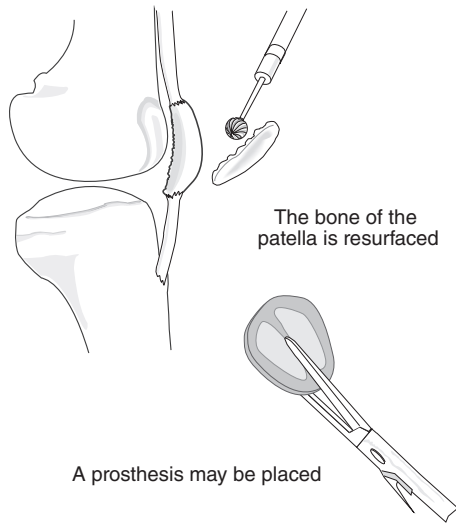
Note that 27306, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Local anesthesia is included in these services. However, these procedures may be performed with the patient under general anesthesia.

ICD-10-CM Diagnostic Codes

- G80.0 Spastic quadriplegic cerebral palsy
- G80.1 Spastic diplegic cerebral palsy
- G80.2 Spastic hemiplegic cerebral palsy
- G80.8 Other cerebral palsy
- M21.261 Flexion deformity, right knee
- M21.262 Flexion deformity, left knee

27437-27438

27437 Arthroplasty, patella; without prosthesis
27438 with prosthesis



Explanation

The physician makes a medial patellar incision, exposing the underneath surface (subchondral bone) of the patella. Abrasion arthroplasty or a smoothing of the bone surface is performed to encourage growth of new cartilage. If cancellous bone is exposed and abrasion arthroplasty would not be effective, the physician may place a prosthesis (also called hemiarthroplasty) on the back side of the patella in 27438. The underneath side of the patella is smoothed to make room for the prosthesis. The physician secures the prosthesis with screws or glue. The prosthesis sits in the trochlear groove in the position where the patella slides up and down when the knee bends and straightens. The incision is repaired in layers with sutures, staples, and/or Steri-strips.

Coding Tips

When 27437 or 27438 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For arthroscopic abrasion arthroplasty (including chondroplasty where necessary) or multiple drilling, see 29879. For patellectomy or hemipatellectomy, see 27350. For reconstruction of a recurrent dislocating patella, see 27420–27424.

ICD-10-CM Diagnostic Codes

- M05.061 Felty's syndrome, right knee
- M05.461 Rheumatoid myopathy with rheumatoid arthritis of right knee
- M17.11 Unilateral primary osteoarthritis, right knee
- M24.461 Recurrent dislocation, right knee
- M76.51 Patellar tendinitis, right knee

AMA: 27438 2023, Apr; 2021, Sep; 2021, Feb

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|-------|-------|------|-------|
| 27437 | 8.93 | 9.26 | 1.77 | 19.96 |
| 27438 | 11.89 | 11.04 | 2.35 | 25.28 |
| Facility RVU | Work | PE | MP | Total |
| 27437 | 8.93 | 9.26 | 1.77 | 19.96 |
| 27438 | 11.89 | 11.04 | 2.35 | 25.28 |

| | FUD | Status | MUE | Modifiers | | | IOM Reference | |
|--------------|-----|--------|------|-----------|----|-----|---------------|------|
| 27437 | 90 | A | 1(2) | 51 | 50 | 62* | N/A | None |
| 27438 | 90 | A | 1(2) | 51 | 50 | 62* | 80 | |

* with documentation

Terms To Know

arthroplasty. Surgical reconstruction of a joint to improve function and reduce pain; may involve partial or total joint replacement.

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.

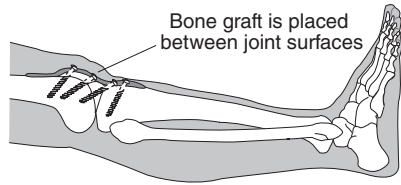
osteoarthritis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.

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

prosthesis. Man-made substitute for a missing body part.

27580

27580 Arthrodesis, knee, any technique



U-shaped bone cuts are made on the underneath side of the patella and on the femur

An internal or external fixator fuses the joint surfaces

Explanation

The physician makes a long incision along the inside of the patella. The patella is reflected laterally to expose the knee joint. Bone cuts are made to flatten out the joint surfaces of the femur and tibia. A U-shaped groove is made on the underneath side of the patella and a corresponding one on the femur. The patella is placed into the femoral groove and secured with screws. The physician makes an incision overlying the iliac crest, harvests a graft, and closes the surgically created graft donor site. The bone graft is placed between the joint surfaces. An external fixator compresses the joint surfaces. The knee is typically fused in 10 to 15 degrees of flexion. The incision is closed with sutures, staples, and/or Steri-strips.

Coding Tips

This code includes any technique the physician may perform. When 27580 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For radiology services, see 73560-73580.

ICD-10-CM Diagnostic Codes

- M00.061 Staphylococcal arthritis, right knee
- M02.361 Reiter's disease, right knee

AMA: 27580 2023, Apr; 2021, Jul; 2020, May

Relative Value Units/Medicare Edits

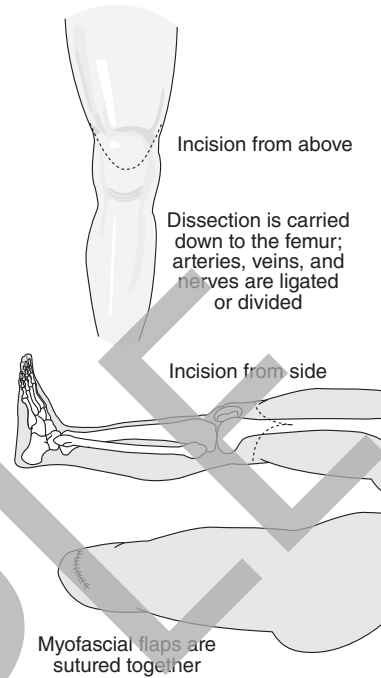
| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|-------|------|-------|
| 27580 | 21.1 | 18.87 | 4.21 | 44.18 |
| Facility RVU | Work | PE | MP | Total |
| 27580 | 21.1 | 18.87 | 4.21 | 44.18 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|--------------|-----|--------|------|-----------|----|-----|----|---------------|
| 27580 | 90 | A | 1(2) | 51 | 50 | 62* | 80 | None |

* with documentation

27590-27591

27590 Amputation, thigh, through femur, any level;
27591 immediate fitting technique including first cast



Explanation

The physician makes incisions so that equal anterior and posterior flaps are fashioned. Dissection is carried down to the femur. Arteries and veins are doubly ligated and transected. The sciatic nerve is divided. A Gigli saw is used to section the femur and bevel the cut ends. The anterior and posterior myofascial flaps are sutured together and secured to the lower end of the femur through drill holes. Incisions are closed in layers and a temporary drain is applied. For fitting (27591) an immediate postoperative prosthesis (IPOP), a rigid dressing is applied at the time of amputation. A closed-end stump sock is placed over the dressings. Felt pads are used over bony prominences to evenly distribute the pressure. An elastic, plaster cast is applied over the amputation site. A belt suspension apparatus may be incorporated into the cast. If immediate weight bearing is planned, an end-plate is wrapped into the lower portion of the cast to allow attachment of a temporary prosthesis.

Coding Tips

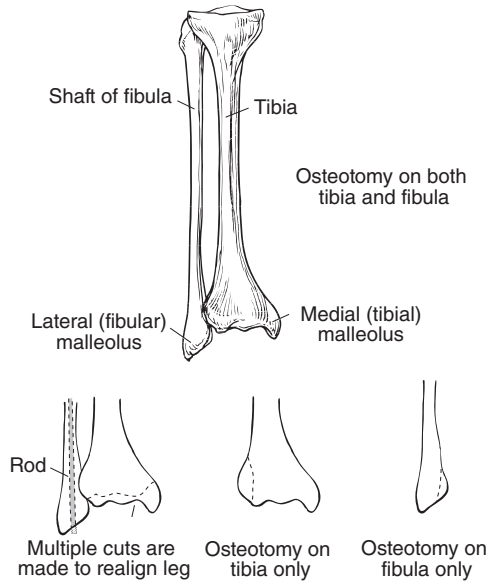
When 27590 or 27591 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Adjacent tissue transfer is included. However, any free grafts or flaps should be reported separately. For open amputation of the thigh, through femur, any level, circular (guillotine), see 27592. For re-amputation of thigh, through femur, see 27596. For radiology services, see 73551-73552.

ICD-10-CM Diagnostic Codes

- I73.01 Raynaud's syndrome with gangrene
- I73.1 Thromboangiitis obliterans [Buerger's disease]
- I74.3 Embolism and thrombosis of arteries of the lower extremities
- I79.8 Other disorders of arteries, arterioles and capillaries in diseases classified elsewhere
- I96 Gangrene, not elsewhere classified

27705-27709

- 27705** Osteotomy; tibia
- 27707** fibula
- 27709** tibia and fibula



Explanation

The physician performs an osteotomy (bone cut) of the tibia in 27705, of the fibula in 27707, or of both in 27709. An incision is made in the skin overlying the osteotomy site. Separate incisions may be necessary to access both tibia and fibula in 27709. The physician dissects the tissues down to the bone. The bone is exposed. The physician makes a cut through the tibia, fibula, or both in the desired location and plane. The bone is aligned to the proper position. Fixation, such as screws or plates may be applied to maintain position. The physician irrigates the area with antibiotic solution and closes it in layers. A splint, cast, or brace may be applied.

Coding Tips

These are unilateral procedures. 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). According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. These codes report osteotomy in the lower leg and ankle. To report osteotomy to correct genu varus (bowleg) or genu valgus (knock-knee), see 27455–27457. For radiology services, see 73590–73615.

ICD-10-CM Diagnostic Codes

- M17.11 Unilateral primary osteoarthritis, right knee
- M21.061 Valgus deformity, not elsewhere classified, right knee
- M21.161 Varus deformity, not elsewhere classified, right knee

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|-------|-------|------|-------|
| 27705 | 10.86 | 9.83 | 1.97 | 22.66 |
| 27707 | 4.78 | 6.62 | 0.85 | 12.25 |
| 27709 | 17.48 | 13.29 | 3.18 | 33.95 |
| Facility RVU | Work | PE | MP | Total |
| 27705 | 10.86 | 9.83 | 1.97 | 22.66 |
| 27707 | 4.78 | 6.62 | 0.85 | 12.25 |
| 27709 | 17.48 | 13.29 | 3.18 | 33.95 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|--------------|-----|--------|------|-----------|----|-----|-----|---------------|
| 27705 | 90 | A | 1(3) | 51 | 50 | 62* | 80 | None |
| 27707 | 90 | A | 1(3) | 51 | 50 | 62* | N/A | |
| 27709 | 90 | A | 1(3) | 51 | 50 | 62* | 80 | |

* with documentation

Terms To Know

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

dissection. Separating by cutting tissue or body structures apart.

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

incision. Act of cutting into tissue or an organ.

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

malunion. Fracture that has united in a faulty position due to inadequate reduction of the original fracture, insufficient holding of a previously well-reduced fracture, contracture of the soft tissues, or comminuted or osteoporotic bone causing a slow disintegration of the fracture.

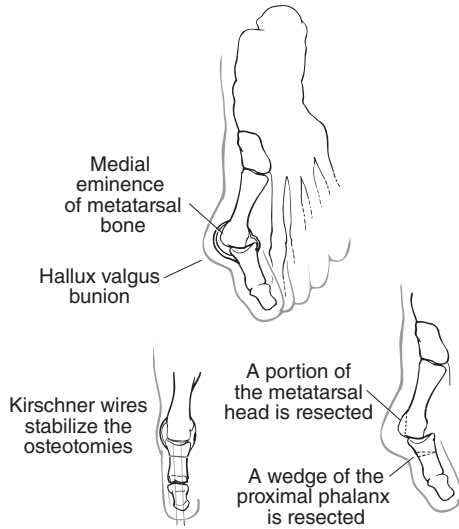
osteitis condensans. Inflammation of the bones with hard, dense deposits of mineral salts.

osteogenesis imperfecta. Hereditary collagen disorder that produces brittle, osteoporotic bones that are easily fractured, with hypermobility of joints, blue sclerae and a tendency to hemorrhage.

osteotomy. Surgical cutting of a bone.

28299

▲ **28299** Correction, hallux valgus with 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. The physician makes an incision over the first metatarsal. Various methods of double osteotomy may be performed. In one method, 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. Removal of the sesamoid bones, if performed, is included.

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. For first metatarsal-cuneiform joint fusion without accompanying removal of the distal medial prominence of the first metatarsal for hallux valgus correction, see 28740. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For 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 2023, Apr

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|-------|------|-------|
| 28299 | 9.29 | 19.74 | 1.02 | 30.05 |
| Facility RVU | Work | PE | MP | Total |
| 28299 | 9.29 | 7.32 | 1.02 | 17.63 |

| | 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.

G0247

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

Explanation

Routine foot care is provided by a physician to a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation and must include, when present, all of the following: local care of superficial wounds, debridement of corns and calluses, and trimming and debridement of nails.

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. Modifier Q7, Q8, or Q9 should be used to indicate a significant systemic condition (e.g., diabetes mellitus, peripheral neuropathies involving the feet) that puts the patient at risk for problems with wound healing and potential loss of limb. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

| | |
|--------|---|
| E08.42 | Diabetes mellitus due to underlying condition with diabetic polyneuropathy |
| E09.42 | Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy |
| E10.41 | Type 1 diabetes mellitus with diabetic mononeuropathy |
| E10.42 | Type 1 diabetes mellitus with diabetic polyneuropathy |
| E10.44 | Type 1 diabetes mellitus with diabetic amyotrophy |
| E10.49 | Type 1 diabetes mellitus with other diabetic neurological complication |
| E13.41 | Other specified diabetes mellitus with diabetic mononeuropathy |

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| G0247 | 0.5 | 1.98 | 0.02 | 2.5 |
| Facility RVU | Work | PE | MP | Total |
| G0247 | 0.5 | 0.12 | 0.02 | 0.64 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|--------------|-----|--------|------|-----------|-----|-----|-----|---------------|
| G0247 | N/A | R | 1(2) | N/A | N/A | N/A | 80* | None |

* with documentation

Terms To Know

atherosclerosis. Buildup of yellowish plaques composed of cholesterol and lipid material within the arteries.

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

G0281-G0283

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281

G0283 Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Explanation

Electrical stimulation is the use of electric current that mimics the body's own natural bioelectric system's current when injured or impaired, and jumpstarts or accelerates the healing process by attracting the body's repair cells, changing cell membrane permeability and hence cellular secretion, and orientating cell structures. A current is generated between the skin and inner tissues when there is a break in the skin. The current is kept flowing until the open skin defect is repaired. There may be different types of electricity used, controlled by different electrical sources. A moist wound environment is required for capacitively coupled electrical stimulation, which involves using a surface electrode pad in wet contact (capacitively coupled) with the external skin surface and/or wound bed. Two electrodes are required to complete the electric circuit and are usually placed over a wet conductive medium in the wound bed and on the skin away from the wound. One of the most safe and effective wavelengths used is monophasic twin peaked high voltage pulsed current (HVPC), allowing for selection of polarity, variation in pulse rates, and very short pulse duration. Significant changes in tissue pH and temperature are avoided, which is good for healing. Codes G0281 and G0282 are reported for wound care. Code G0283 is reported for purposes other than wound care, such as nerve stimulation, pain reduction, and muscle contraction.

Coding Tips

Medicare covers G0281 and G0282 for the treatment of chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers only. In addition, the use of electrical stimulation will only be covered by Medicare after appropriate standard wound care has been tried for at least 30 days and there are no measurable signs of healing. If electrical stimulation is being used, wounds must be evaluated periodically by the treating physician but no less than every 30 days. Continued treatment with electrical stimulation is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. Additionally, electrical stimulation must be discontinued when the wound demonstrates a 100 percent epithelialized wound bed. Electrical stimulation for non-wound purposes (G0283) must be documented in the patient record. Third-party payers may not separately reimburse for this service. Check with the payer for their specific guidelines.

ICD-10-CM Diagnostic Codes

| | | |
|---------|---|---|
| L89.214 | Pressure ulcer of right hip, stage 4 | ✓ |
| L89.216 | Pressure-induced deep tissue damage of right hip | ✓ |
| L89.43 | Pressure ulcer of contiguous site of back, buttock and hip, stage 3 | |
| L89.514 | Pressure ulcer of right ankle, stage 4 | ✓ |
| L89.516 | Pressure-induced deep tissue damage of right ankle | ✓ |
| L89.613 | Pressure ulcer of right heel, stage 3 | ✓ |
| L89.616 | Pressure-induced deep tissue damage of right heel | ✓ |