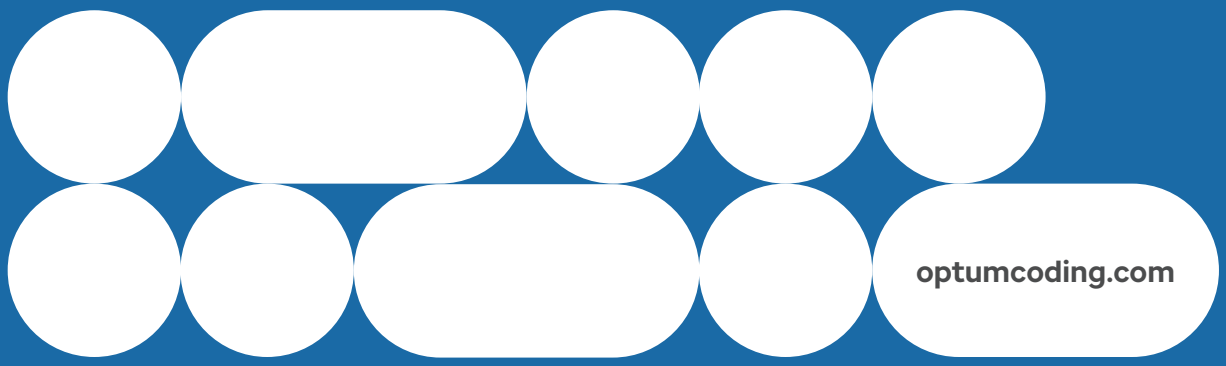
Optum

Coding Companion

Podiatry

A comprehensive illustrated guide to coding and reimbursement

2027



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Contents

Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

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

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

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

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 32.3, 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 2027 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

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

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

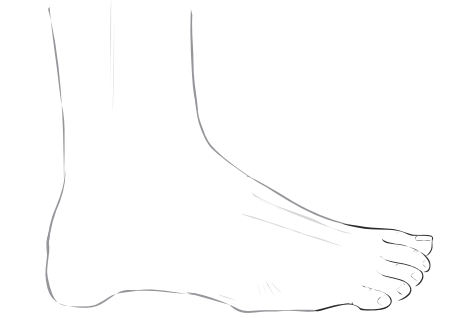
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

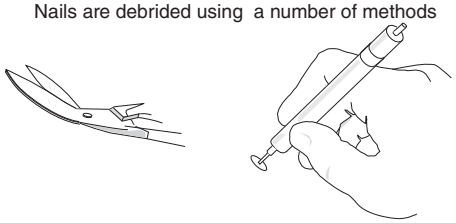
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

11720-11721

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



Nails are debrided using a number of methods



Explanation

The physician debrides toenails, including tops and exposed undersides, by any method. The cleaning is performed manually with cleaning solutions, abrasive materials, and tools. The nails are shortened and shaped. Report 11720 for one to five nails and 11721 for six or more.

Coding Tips

These codes are reported only once regardless of the number of nails that are trimmed. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. For trimming of nondystrophic nails, see 11719. For the trimming of dystrophic nails, see G0127.

ICD-10-CM Diagnostic Codes

B35.1	Tinea unguium
B37.2	Candidiasis of skin and nail
L03.031	Cellulitis of right toe ☑
L03.032	Cellulitis of left toe ☑
L60.0	Ingrowing nail
L60.1	Onycholysis
L60.2	Onychogryphosis
L60.3	Nail dystrophy
L60.8	Other nail disorders
Q84.6	Other congenital malformations of nails

Associated HCPCS Codes

G0127	Trimming of dystrophic nails, any number
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
S0390	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11720	0.32	0.64	0.03	0.99
11721	0.54	0.76	0.04	1.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
11720	0.32	0.07	0.03	0.42
11721	0.54	0.12	0.04	0.7

	FUD	Status	MUE	Modifiers				IOM Reference
11720	0	A	1(2)	N/A	N/A	N/A	N/A	None
11721	0	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

cellulitis. Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

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

LOPS. Loss of protective sensation. Reduction in anatomic nerve function so the patient cannot sense minor trauma from heat, chemicals, or mechanical sources. This disorder is usually associated with the foot, and secondary to another disorder like diabetes or amyloidosis.

neuropathy. Abnormality, disease, or malfunction of the nerves.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2027

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2027
- ▲ This CPT code description is revised for 2027
- ✚ This CPT code is an add-on code.

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

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

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

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	9949					

2. Illustrations

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

3. Explanation

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

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

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

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2026.

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Oct; 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

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

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

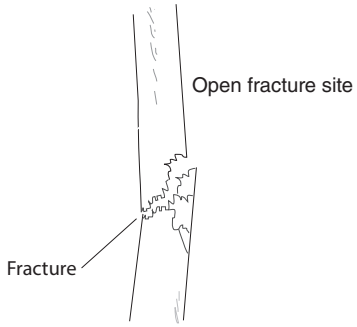
● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

11010-11012

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues

11011 skin, subcutaneous tissue, muscle fascia, and muscle

11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone



Explanation

The physician surgically removes foreign matter and contaminated or devitalized skin and other tissue in and around the site of an open fracture or open dislocation. Debridement reported with this service includes prolonged cleansing of the wound; removal of all foreign or dead tissue or material using forceps, scissors, scalpel, or other instruments; exploration of all injured soft tissue, including tendons, ligaments, and nerves; and irrigation of all tissue layers. Contamination of a wound by foreign matter is typically associated with open fractures; this excisional debridement is done in preparation for treating the fracture, to reduce swelling and bleeding, and to leave behind viable tissue. Report 11010 for debridement of skin and subcutaneous tissue; 11011 for debridement of skin, subcutaneous tissue, muscle fascia, and muscle; and 11012 for debridement of skin, subcutaneous tissue, muscle fascia, muscle, and bone.

Coding Tips

Debridement associated with open fractures and/or dislocations may be reported separately when gross contamination requires prolonged cleansing and removal of appreciable amounts of devitalized or contaminated tissue. When debridement 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. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For debridement of subcutaneous tissue, muscle, and bone not associated with open fracture/dislocation, see 11042–11047. For debridement of skin (e.g., epidermis and/or dermis only), see 97597 and 97598. For debridement of burn wounds, see 16020–16030.

ICD-10-CM Diagnostic Codes

S82.61XB Displaced fracture of lateral malleolus of right fibula, initial encounter for open fracture type I or II ☑

S82.841B Displaced bimalleolar fracture of right lower leg, initial encounter for open fracture type I or II ☑

S92.031B Displaced avulsion fracture of tuberosity of right calcaneus, initial encounter for open fracture ☑

S92.141B Displaced dome fracture of right talus, initial encounter for open fracture ☑

S92.311B Displaced fracture of first metatarsal bone, right foot, initial encounter for open fracture ☑

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

S92.511B Displaced fracture of proximal phalanx of right lesser toe(s), initial encounter for open fracture ☑

AMA: **11010** 2023,Jun; 2022,Feb; 2021,Sep **11011** 2023,Jun; 2023,Apr; 2022,Feb; 2021,Sep **11012** 2023,Jun; 2023,Apr; 2022,Feb; 2021,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11010	4.19	8.51	0.74	13.44
11011	4.94	9.1	0.97	15.01
11012	6.87	11.33	1.34	19.54
Facility RVU	**Work**	**PE**	**MP**	**Total**
11010	4.19	3.33	0.74	8.26
11011	4.94	2.97	0.97	8.88
11012	6.87	4.19	1.34	12.4

	FUD	Status	MUE	Modifiers				IOM Reference
11010	10	A	2(3)	51	N/A	N/A	N/A	None
11011	0	A	2(3)	51	N/A	N/A	N/A	
11012	0	A	2(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

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

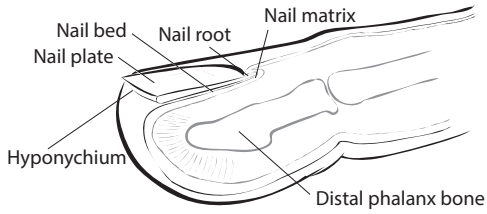
fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

open fracture. Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture. Broken bone ends may protrude through the skin and contaminants or foreign bodies are often embedded in the tissues.

11755

11755 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)



A nail specimen is collected by any method for biopsy

Explanation

The physician removes a portion of the nail unit for a biopsy sample. Sections may be taken from the hard nail itself, the nail bed, lateral skin, or underlying soft tissue. The specimen is excised by clippers or with a scalpel.

Coding Tips

This separate procedure 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. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Some payers may require the use of HCPCS Level II modifiers TA–T9 to identify the specific toe involved. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

ICD-10-CM Diagnostic Codes

B35.1	Tinea unguium
C79.2	Secondary malignant neoplasm of skin
D04.71	Carcinoma in situ of skin of right lower limb, including hip ☑
D04.72	Carcinoma in situ of skin of left lower limb, including hip ☑
D23.71	Other benign neoplasm of skin of right lower limb, including hip ☑
D23.72	Other benign neoplasm of skin of left lower limb, including hip ☑
D48.5	Neoplasm of uncertain behavior of skin
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
L60.1	Onycholysis
L60.3	Nail dystrophy
L60.5	Yellow nail syndrome
L60.8	Other nail disorders
L62	Nail disorders in diseases classified elsewhere

AMA: **11755** 2022,Feb; 2021,Aug; 2019,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11755	1.25	2.32	0.1	3.67
Facility RVU	**Work**	**PE**	**MP**	**Total**
11755	1.25	0.45	0.1	1.8

	FUD	Status	MUE	Modifiers				IOM Reference
11755	0	A	2(3)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

dermatophytosis. Superficial parasitic fungal infections occurring in the skin, hair, or nails that involve the corneal stratum, or outermost layer of cells, commonly referring to ringworm and athlete's foot.

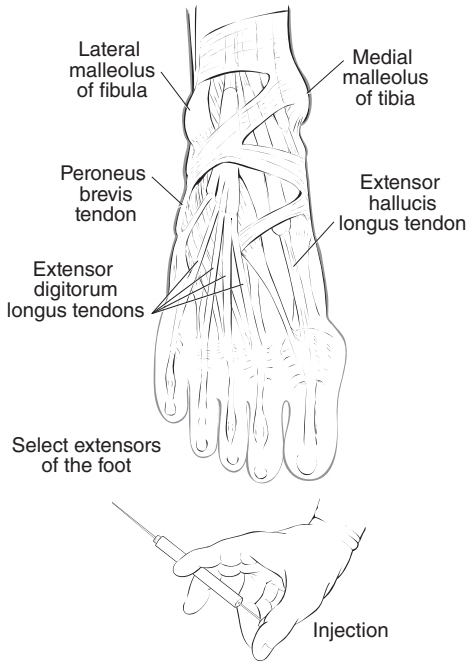
nail bed. Area of dermal layer beneath the nail.

nail matrix. Area of dermal layer beneath the nail and proximal skin including the nail bed.

separate procedures. Services commonly carried out as a fundamental part of a total service and, as such, do not usually warrant separate identification. These services are identified in CPT with the parenthetical phrase (separate procedure) at the end of the description and are payable only when performed alone.

20552-20553

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



Trigger points of one or two muscle groups are injected

Explanation

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

Coding Tips

Local anesthesia is included in these services. If imaging guidance is performed, see 76942, 77002, and 77021. For therapeutic injection of carpal tunnel, see 20526. For injection of a tendon sheath or ligament, see 20550. For injection of a tendon origin/insertion, see 20551. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage. Do not report these codes with 20560 or 20561 when the same muscles are being treated.

ICD-10-CM Diagnostic Codes

G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.18 Other acute postprocedural pain
G89.21 Chronic pain due to trauma
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M25.571 Pain in right ankle and joints of right foot ☑
M25.572 Pain in left ankle and joints of left foot ☑
M25.59 Pain in other specified joint
M70.861 Other soft tissue disorders related to use, overuse and pressure, right lower leg ☑
M70.862 Other soft tissue disorders related to use, overuse and pressure, left lower leg ☑
M70.871 Other soft tissue disorders related to use, overuse and pressure, right ankle and foot ☑
M70.872 Other soft tissue disorders related to use, overuse and pressure, left ankle and foot ☑
M70.88 Other soft tissue disorders related to use, overuse and pressure other site
M70.89 Other soft tissue disorders related to use, overuse and pressure multiple sites
M72.2 Plantar fascial fibromatosis
M79.604 Pain in right leg ☑
M79.605 Pain in left leg ☑
M79.661 Pain in right lower leg ☑
M79.662 Pain in left lower leg ☑
M79.671 Pain in right foot ☑
M79.672 Pain in left foot ☑
M79.674 Pain in right toe(s) ☑
M79.675 Pain in left toe(s) ☑
M79.7 Fibromyalgia

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

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

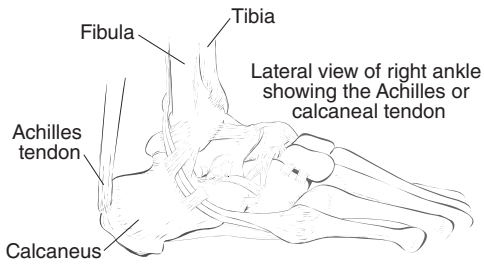
injection. Forcing a liquid substance into a body part such as a joint or muscle.

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

27605-27606

27605 Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia

27606 general anesthesia



The Achilles tendon is approached through the skin and its attachment to the heel bone is cut

Explanation

The physician performs a percutaneous tenotomy of the Achilles tendon. The physician infiltrates the skin and Achilles tendon with a local anesthetic about 1 cm above the insertion into the calcaneus. A knife blade or tenotome held vertically is inserted through the skin and subcutaneous tissue into the Achilles tendon. The blade is turned medially and laterally and swept back forth, creating a nick in the tendon, until the foot can be dorsiflexed at the ankle. Pressure is applied over the incision for about five minutes. A dressing and long leg cast is applied with the ankle in ten degree dorsiflexion and the knee in maximal extension. Report 27605 if performed with local anesthesia; report 27606 if general anesthesia is required.

Coding Tips

These separate procedures by definition are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services they may be reported. If performed alone, list the code; if performed with other unrelated procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery section, under Musculoskeletal System. For Achilles tendon lengthening, see 27685.

ICD-10-CM Diagnostic Codes

M67.01 Short Achilles tendon (acquired), right ankle ☑

M67.02 Short Achilles tendon (acquired), left ankle ☑

M76.61 Achilles tendinitis, right leg ☑

M76.62 Achilles tendinitis, left leg ☑

AMA: **27605** 2018,Sep **27606** 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27605	2.92	6.68	0.29	9.89
27606	4.18	3.33	0.63	8.14
Facility RVU	**Work**	**PE**	**MP**	**Total**
27605	2.92	2.31	0.29	5.52
27606	4.18	3.33	0.63	8.14

	FUD	Status	MUE	Modifiers				IOM Reference
27605	10	A	1(2)	51	50	N/A	80*	None
27606	10	A	1(2)	51	50	62*	N/A	

* with documentation

Terms To Know

Achilles tendon. Tendon attached to the back of the heel bone (calcaneus) that flexes the foot downward.

contracture. Shortening of muscle or connective tissue.

dorsiflexion. Position of being bent toward the extensor side of a limb.

general anesthesia. State of unconsciousness produced by an anesthetic agent or agents, inducing amnesia by blocking the awareness center in the brain, and rendering the patient unable to control protective reflexes, such as breathing.

incision. Act of cutting into tissue or an organ.

lateral. On/to the side.

local anesthesia. Induced loss of feeling or sensation restricted to a certain area of the body, including topical, local tissue infiltration, field block, or nerve block methods.

medial. Middle or midline.

percutaneous. Through the skin.

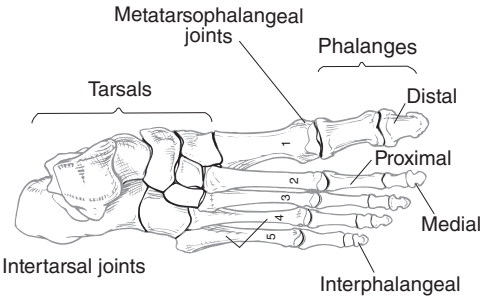
subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

tenosynovitis. Inflammation of a tendon sheath due to infection or disease.

tenotomy. Cutting into a tendon.

28020-28024

28020 Arthrotomy, including exploration, drainage, or removal of loose or foreign body; intertarsal or tarsometatarsal joint
28022 metatarsophalangeal joint
28024 interphalangeal joint



An arthrotomy of an intertarsal or tarsometatarsal joint is performed, including exploration, drainage, or removal of loose or foreign body

Explanation

The physician performs an arthrotomy of an intertarsal or tarsometatarsal joint in 28020, a metatarsophalangeal joint in 28022, or an interphalangeal joint in 28024 that includes exploration, drainage, or removal of any loose or foreign body. An incision is made over the joint to be exposed. The soft tissues are dissected away and the joint capsule is exposed and incised. The joint space is explored, any necrotic tissue is removed, and infection or abnormal fluid is drained. If a foreign body is present (e.g., bullet, nail, gravel), it is exposed and removed. The wound is irrigated with antibiotic solution. The physician may leave the wound packed open with daily dressing changes to allow for drainage and secondary healing by granulation. If the incision is repaired, drain tubes may be inserted and the incision is closed in layers with sutures, staples, and/or Steri-strips.

Coding Tips

This procedure involves incision into the joint (arthrotomy). For incision and drainage of an abscess, not requiring an incision into the joint, see 28001–28003. For arthrotomy with a biopsy, see 28050–28054.

ICD-10-CM Diagnostic Codes

L02.611 Cutaneous abscess of right foot ☑
L03.115 Cellulitis of right lower limb ☑
L03.125 Acute lymphangitis of right lower limb ☑
M00.071 Staphylococcal arthritis, right ankle and foot ☑
M00.171 Pneumococcal arthritis, right ankle and foot ☑
M00.871 Arthritis due to other bacteria, right ankle and foot ☑
M24.074 Loose body in right toe joint(s) ☑
M25.774 Osteophyte, right foot ☑
M77.41 Metatarsalgia, right foot ☑
M79.5 Residual foreign body in soft tissue
M86.371 Chronic multifocal osteomyelitis, right ankle and foot ☑
M86.471 Chronic osteomyelitis with draining sinus, right ankle and foot ☑
M89.771 Major osseous defect, right ankle and foot ☑
S91.121A Laceration with foreign body of right great toe without damage to nail, initial encounter ☑
S91.321A Laceration with foreign body, right foot, initial encounter ☑
S91.341A Puncture wound with foreign body, right foot, initial encounter ☑
T84.213A Breakdown (mechanical) of internal fixation device of bones of foot and toes, initial encounter
T84.223A Displacement of internal fixation device of bones of foot and toes, initial encounter
T84.318A Breakdown (mechanical) of other bone devices, implants and grafts, initial encounter
T84.418A Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter
T84.428A Displacement of other internal orthopedic devices, implants and grafts, initial encounter
T84.59XA Infection and inflammatory reaction due to other internal joint prosthesis, initial encounter
T84.7XXA Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.82XA Fibrosis 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

AMA: 28020 2023,Apr; 2021,Sep; 2020,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28020	5.15	10.47	0.67	16.29
28022	4.81	9.28	0.54	14.63
28024	4.52	8.9	0.46	13.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
28020	5.15	5.26	0.67	11.08
28022	4.81	4.58	0.54	9.93
28024	4.52	4.37	0.46	9.35

	FUD	Status	MUE	Modifiers				IOM Reference
28020	90	A	2(3)	51	N/A	62*	N/A	None
28022	90	A	3(3)	51	N/A	N/A	N/A	
28024	90	A	4(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

arthrotomy. Surgical incision into a joint that may include exploration, drainage, or removal of a foreign body.

drainage. Releasing, taking, or letting out fluids and/or gases from a body part.

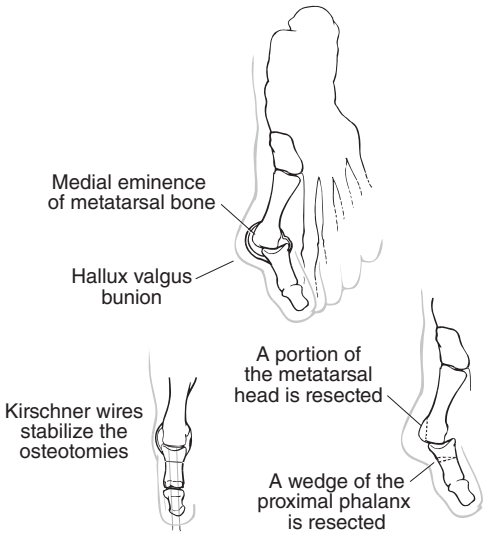
exploration. Examination for diagnostic purposes.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

joint. Area of contact, or juncture, between two or more bones, often articulating with each other.

28298

28298 Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with proximal phalanx osteotomy, any method



Explanation

The physician treats a bunion of the foot with proximal phalanx osteotomy by any method. This procedure consists of removal of a bony wedge from the base of the proximal phalanx. A medial based wedge (0.3 mm to 0.4 mm) is cut, allowing reorientation of bone while leaving the lateral cortex intact. The medial eminence is excised. Fixation is usually accomplished by crossed K-wires, pins, or screws. The wound is closed in layers after irrigation. Removal of the sesamoid bones, if performed, is included.

Coding Tips

To correct severe hallux valgus deformities, this procedure may be used in combination with other techniques. When used in combination with other methods (e.g., double osteotomy), see 28299. Code 28298 requires the removal of the medial eminence of the first metatarsal bunion. 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. For first metatarsal-cuneiform joint fusion without accompanying removal of the distal medial prominence of the first metatarsal for hallux valgus correction, see 28740.

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: **28298** 2024,Nov; 2023,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28298	7.75	16.39	0.94	25.08
Facility RVU	**Work**	**PE**	**MP**	**Total**
28298	7.75	6.69	0.94	15.38

	FUD	Status	MUE	Modifiers				IOM Reference
28298	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

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

excise. Remove or cut out.

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

hallux malleus. Deformity in which there is hammertoe of the great toe.

hallux rigidus. Deformity in which there is severe flexion of the great toe causing pain and limited movement.

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

hallux varus. Deformity in which the great toe deviates away from the other toes.

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

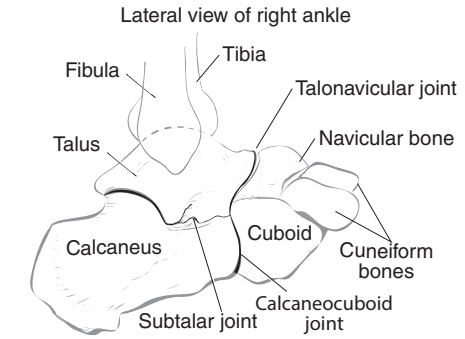
osteotomy. Surgical cutting of a bone.

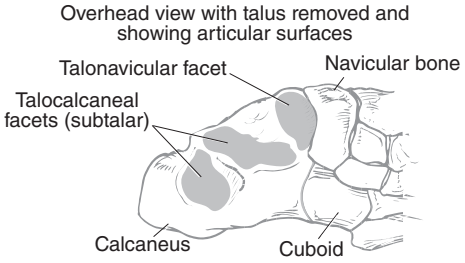
sesamoid bone. Small bone found embedded in a tendon. Sesamoid bones can be found in several anatomical locations, including the foot, hand, and knee.

sesamoidectomy. Excision of a small, nodular (sesamoid) bone in tendons or joint capsules.

28715

28715 Arthrodesis; triple





Explanation

The physician fuses the talonavicular, the calcaneocuboid, and the subtalar (talocalcaneal) joints. The physician makes incisions on each side of the foot. These are carried deep to the joints. Tendons are reflected and protected. Each joint is identified. Soft tissues are debrided. The capsules are opened and the joints visualized. Surgical curettes are used to remove the articular cartilage of the joints one at a time so that viable bone is exposed. The physician uses any of a variety of surgical fixation devices including screws, plates, or wires to connect the bones of each individual joint together. The incisions are irrigated and closed in layers. A cast is applied and continued until all three joints are solidly fused.

Coding Tips

Triple arthrodesis refers to fusion of the subtalar (talocalcaneal), calcaneocuboid, and talonavicular joints. 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 fusion of the tibiotalar joint, see 27870. For fusion of the distal tibiofibular joint, see 27871. For pantalar arthrodesis, see 28705. For subtalar arthrodesis, see 28725. For radiology services for the ankle, calcaneus, or foot, see 73600–73650.

ICD-10-CM Diagnostic Codes

G14 Postpolio syndrome

M05.771 Rheumatoid arthritis with rheumatoid factor of right ankle and foot without organ or systems involvement ☑

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

M12.571 Traumatic arthropathy, right ankle and foot ☑

M19.071 Primary osteoarthritis, right ankle and foot ☑

M19.171 Post-traumatic osteoarthritis, right ankle and foot ☑

M19.271 Secondary osteoarthritis, right ankle and foot ☑

M21.371 Foot drop, right foot ☑

M21.541 Acquired clubfoot, right foot ☑

M25.271 Flail joint, right ankle and foot ☑

M25.374 Other instability, right foot ☑

AMA: **28715** 2023,Apr; 2021,Jul; 2020,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28715	13.42	12.67	2.3	28.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
28715	13.42	12.67	2.3	28.39

	FUD	Status	MUE	Modifiers				IOM Reference
28715	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.

Felty's syndrome. Splenomegaly, leukopenia, arthritis, hypersplenism, anemia and other symptoms.

fusion. Union of adjacent tissues, especially bone.

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

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 appended 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 offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy
E10.44 Type 1 diabetes mellitus with diabetic amyotrophy
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
E11.44 Type 2 diabetes mellitus with diabetic amyotrophy
E13.44 Other specified diabetes mellitus with diabetic amyotrophy
E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0247	0.5	2.01	0.02	2.53
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 lipoid 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 and jump starts or accelerates the wound 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 capacitatively coupled electrical stimulation, which involves using a surface electrode pad in wet contact (capacitatively 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.

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

I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot A ☑
I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle A ☑
I70.45 Atherosclerosis of autologous vein bypass graft(s) of other extremity with ulceration A
I70.541 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of thigh A ☑
I70.542 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf A ☑
I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot A ☑

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 AMA: CPT Assist

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0232T 36415, 36591-36592, 76380, 76942, 76998, 77002, 77012, 77021, 86965, 96523, 99446-99449, 99451-99452

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0859T No CCI edits apply to this code.

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