Optum

Coding Companion

Orthopaedics: Lower–Hips & Below

A comprehensive illustrated guide to coding and reimbursement

2027

optumcoding.com

Contents

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, 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.

11055-11057

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

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 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** 2024,Sep; 2022,Feb **11056** 2022,Feb **11057** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.76	0.03	2.14
11056	0.5	1.94	0.04	2.48
11057	0.65	2.01	0.05	2.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
11055	0.35	0.08	0.03	0.46
11056	0.5	0.11	0.04	0.65
11057	0.65	0.15	0.05	0.85

	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

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 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	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 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

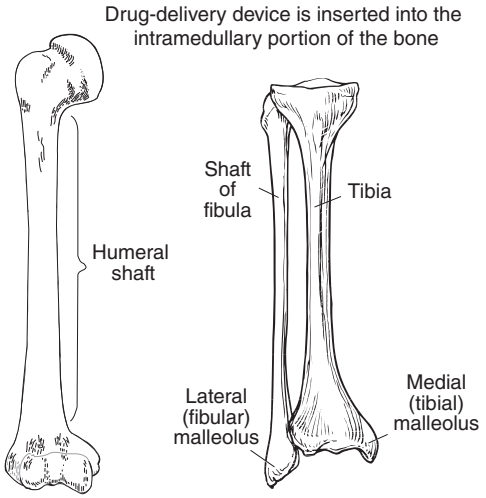
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

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

20702-20703

+ **20702** Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)
+ **20703** Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)



Explanation

In conjunction with open procedures (excluding those in which placement of a spacer is a component of the surgery) in which infection may be anticipated, suspected, or present, the physician or other qualified health care professional manually prepares and inserts a drug-delivery device that is not prefabricated into intramedullary spaces in 20702. Antibiotics or other therapeutic agents are mixed with a carrier substance, shaped into a drug-delivery device, and placed into the intramedullary space. The associated procedures, such as removal of deep implants, application or removal of external fixation systems, reimplantation procedures, bone incision/excision, open treatment of fractures/dislocations, malunion/nonunion repairs, and intramedullary implant insertions, are reported separately. One example includes the preparation of an antibiotic nail to insert into the intramedullary canal in the treatment of a proximal humeral fracture. Removal of an intramedullary device, performed in conjunction with procedures such as bone grafts or nonunion/malunion repair, is reported with 20703.

Coding Tips

Report 20702 in addition to 20680-20692, 20694, 20838, 27245, 27259, 27360, 27470, 27506, 27640, or 27720. Do not report 20702 with 11981, 27091, or 27488. Report 20703 in addition to 27470, 27472, 27720, 27722, 27724, or 27725. Do not report 20703 with 11982. For additional debridement of infected bone, see 11012, 27070, 27071, 27360, 27640, 27641, 28122, or 28124. Additionally, 20702 may be reported with amputation codes 27290, 27590, or 27598. For removal of a drug delivery device only, see 20680. Code 20703 may be reported with primary procedures 13100–13160, 14000–14350, or 15570–15758 when appropriate.

ICD-10-CM Diagnostic Codes

T85.79XA Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter

T85.898A Other specified complication of other internal prosthetic devices, implants and grafts, initial encounter

AMA: **20702** 2023,Apr; 2021,Sep **20703** 2023,Apr; 2021,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20702	2.5	1.25	0.49	4.24
20703	1.8	0.93	0.37	3.1
Facility RVU	**Work**	**PE**	**MP**	**Total**
20702	2.5	1.25	0.49	4.24
20703	1.8	0.93	0.37	3.1

	FUD	Status	MUE	Modifiers				IOM Reference
20702	N/A	A	1(3)	N/A	N/A	N/A	80*	None
20703	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

external fixation. Rods and pins connected in a lattice to secure bone.

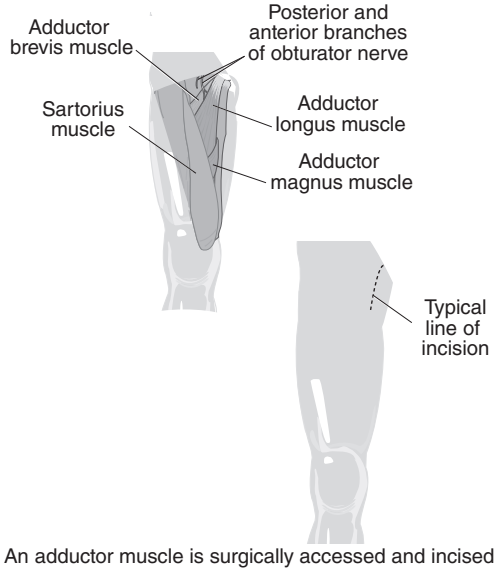
intramedullary implants. Nail, rod, or pin placed into the intramedullary canal at the fracture site. Intramedullary implants not only provide a method of aligning the fracture, they also act as a splint and may reduce fracture pain. Implants may be rigid or flexible. Rigid implants are preferred for prophylactic treatment of diseased bone, while flexible implants are preferred for traumatic injuries.

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.

nonunion. Failure of two ends of a fracture to mend or completely heal.

27001-27003

27001 Tenotomy, adductor of hip, open
27003 Tenotomy, adductor, subcutaneous, open, with obturator neurectomy



An adductor muscle is surgically accessed and incised

Explanation

The physician performs a tenotomy of the adductor of the hip. An incision is made starting at the pubis and extending approximately 5 cm along the inner thigh, in line with the V adductor longus muscle. The tendinous origins of the adductor muscles are identified and separated to allow lengthening. In 27003, the adductor muscles are separated from each other and the obturator nerve is located. The anterior and posterior branches of the nerve are removed. To perform a tenotomy, the tendinous origins of the adductor muscles are divided. The physician repairs the incision in layers. A cast may be applied for three to six weeks to hold the hip in abduction.

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). For a tenotomy, adductor of hip, percutaneous, see 27000. For tenotomy hip flexors, open, see 27005. Note that 27001 and 27003 report procedures on adductors not abductors. For tenotomy, abductors of hip and/or extensors, open, see 27006. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery section, under Musculoskeletal System.

ICD-10-CM Diagnostic Codes

G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.8	Other cerebral palsy
M24.551	Contracture, right hip ☑
M24.552	Contracture, left hip ☑
M24.651	Ankylosis, right hip ☑
M24.652	Ankylosis, left hip ☑
M25.651	Stiffness of right hip, not elsewhere classified ☑
M25.652	Stiffness of left hip, not elsewhere classified ☑
M65.151	Other infective (teno)synovitis, right hip ☑
M65.152	Other infective (teno)synovitis, left hip ☑
M65.251	Calcific tendinitis, right thigh ☑
M65.252	Calcific tendinitis, left thigh ☑
M67.853	Other specified disorders of tendon, right hip ☑
M67.854	Other specified disorders of tendon, left hip ☑
M76.11	Psoas tendinitis, right hip ☑
M76.12	Psoas tendinitis, left hip ☑
S73.011A	Posterior subluxation of right hip, initial encounter ☑
S73.012A	Posterior subluxation of left hip, initial encounter ☑
S73.014A	Posterior dislocation of right hip, initial encounter ☑
S73.015A	Posterior dislocation of left hip, initial encounter ☑
S73.021A	Obturator subluxation of right hip, initial encounter ☑
S73.022A	Obturator subluxation of left hip, initial encounter ☑
S73.024A	Obturator dislocation of right hip, initial encounter ☑
S73.025A	Obturator dislocation of left hip, initial encounter ☑
S73.031A	Other anterior subluxation of right hip, initial encounter ☑
S73.032A	Other anterior subluxation of left hip, initial encounter ☑
S73.034A	Other anterior dislocation of right hip, initial encounter ☑
S73.035A	Other anterior dislocation of left hip, initial encounter ☑
S73.041A	Central subluxation of right hip, initial encounter ☑
S73.042A	Central subluxation of left hip, initial encounter ☑
S73.044A	Central dislocation of right hip, initial encounter ☑
S73.045A	Central dislocation of left hip, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27001	7.14	7.86	1.47	16.47
27003	7.81	8.89	1.61	18.31
Facility RVU	**Work**	**PE**	**MP**	**Total**
27001	7.14	7.86	1.47	16.47
27003	7.81	8.89	1.61	18.31

	FUD	Status	MUE	Modifiers				IOM Reference
27001	90	A	1(3)	51	50	62*	80	None
27003	90	A	1(2)	51	50	62*	80	

* with documentation

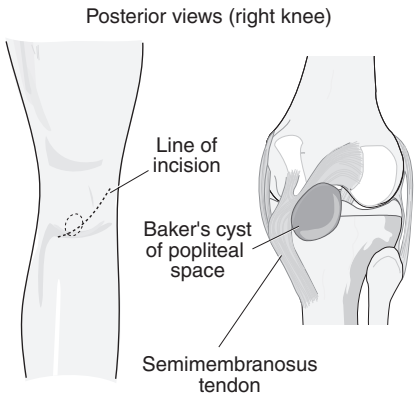
Terms To Know

subcutaneous. Below the skin.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

27345

27345 Excision of synovial cyst of popliteal space (eg, Baker's cyst)



Explanation

A Bakers cyst is located in the popliteal space (back of the knee). The physician makes a popliteal incision, carrying dissection to expose the semimembranosus tendon. The cyst is typically located around this tendon. The cyst is excised from the tendon. The incision is repaired in layers with sutures.

Coding Tips

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). When 27345 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 excision of a lesion of the meniscus or capsule (e.g., cyst or ganglion), knee, see 27347.

ICD-10-CM Diagnostic Codes

M71.21 Synovial cyst of popliteal space [Baker], right knee ☑

M71.22 Synovial cyst of popliteal space [Baker], left knee ☑

Relative Value Units/Medicare Edits

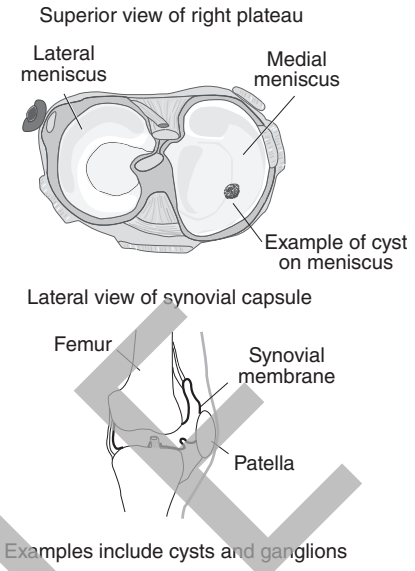
Non-Facility RVU	Work	PE	MP	Total
27345	6.09	7.59	1.22	14.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
27345	6.09	7.59	1.22	14.9

	FUD	Status	MUE	Modifiers				IOM Reference
27345	90	A	1(2)	51	50	62*	80	None

* with documentation

27347

27347 Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee



Explanation

The physician excises a lesion of the meniscus or capsule of the knee. Types of lesions treated include a cyst or ganglion (fluid-filled sac). Lesions may be located in the meniscus - the cartilage between the knee joint - (following an injury), or on the capsule, the fibrous covering over the joint space. Through an incision over the knee the physician dissects the tissues to the level of the cyst or ganglion. The lesion is excised, and the wound is closed with layered sutures.

Coding Tips

This procedure is specific to lesions of the meniscus and capsule of the knee. 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 excision of a synovial cyst of the popliteal space, see 27345.

ICD-10-CM Diagnostic Codes

M23.000 Cystic meniscus, unspecified lateral meniscus, right knee ☑

M23.003 Cystic meniscus, unspecified medial meniscus, right knee ☑

M23.006 Cystic meniscus, unspecified meniscus, right knee ☑

M23.011 Cystic meniscus, anterior horn of medial meniscus, right knee ☑

M23.021 Cystic meniscus, posterior horn of medial meniscus, right knee ☑

M23.031 Cystic meniscus, other medial meniscus, right knee ☑

M23.041 Cystic meniscus, anterior horn of lateral meniscus, right knee ☑

M23.051 Cystic meniscus, posterior horn of lateral meniscus, right knee ☑

M23.061 Cystic meniscus, other lateral meniscus, right knee ☑

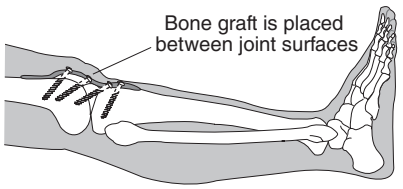
M23.211 Derangement of anterior horn of medial meniscus due to old tear or injury, right knee ☑

M23.221 Derangement of posterior horn of medial meniscus due to old tear or injury, right knee ☑

M23.231 Derangement of other medial meniscus due to old tear or injury, right knee ☑

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

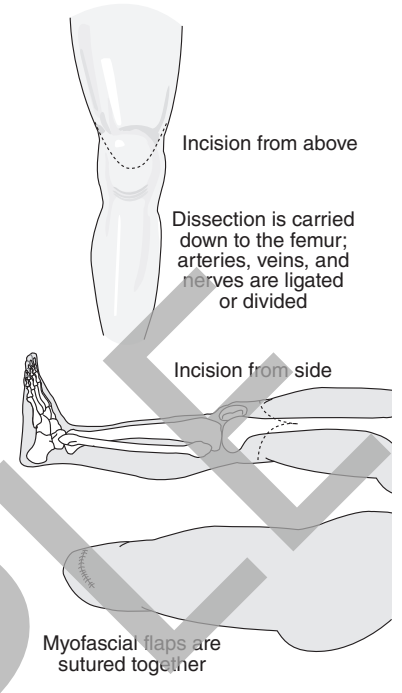
Non-Facility RVU	Work	PE	MP	Total
27580	21.1	19.04	4.36	44.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
27580	21.1	19.04	4.36	44.5

	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

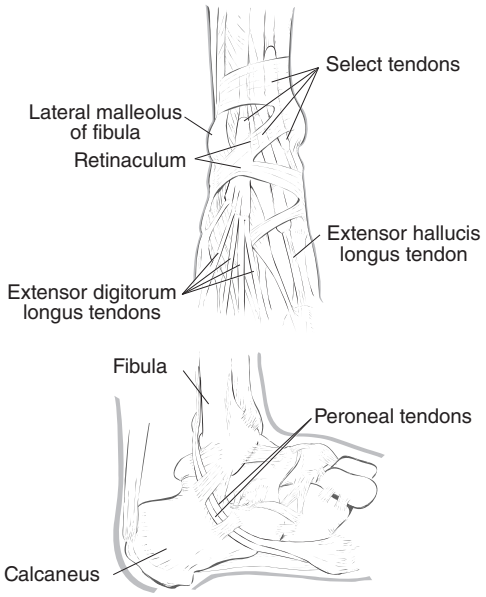
I79.8 Other disorders of arteries, arterioles and capillaries in diseases classified elsewhere

I96 Gangrene, not elsewhere classified

27685-27686

27685 Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)

27686 multiple tendons (through same incision), each



A tendon of the leg or ankle is lengthened or shortened

Explanation

The physician makes three incisions on the lateral side of the foot centered over the sinus tarsi. The physician exposes the extensor digitorum brevis tendon, and reflects it distally to expose the anterior part of the talocalcaneal joint. The calcaneocuboid joint is identified and all tight surrounding structures are released. A second incision is made on the medial side of the foot centered over the prominent head of the talus. The physician releases all tight structures on the medial and dorsal aspects of the head of the talus and the navicular. The anterior part of the talus is freed from its attachments to the navicular and calcaneus. If the peroneal, and extensor hallucis longus and extensor digitorum longus tendons remain contracted the physician lengthens them by Z-plasty. A third incision is made on the medial side of the Achilles tendon, lengthened by Z-plasty. The physician inserts a Steinmann pin through the navicular and into the neck of the talus to maintain the reduction. The wound is closed in layers and a long-leg cast with the knee flexed and the foot in proper position. The Steinmann pins are removed in eight weeks.

Coding Tips

Note that 27685, 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. When multiple tendons are lengthened or shortened through the same incision, report 27686 for each tendon. 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.

ICD-10-CM Diagnostic Codes

G11.4	Hereditary spastic paraplegia
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G81.11	Spastic hemiplegia affecting right dominant side ☑
G81.12	Spastic hemiplegia affecting left dominant side ☑
G81.13	Spastic hemiplegia affecting right nondominant side ☑
G81.14	Spastic hemiplegia affecting left nondominant side ☑
M21.071	Valgus deformity, not elsewhere classified, right ankle ☑
M21.072	Valgus deformity, not elsewhere classified, left ankle ☑
M21.6X1	Other acquired deformities of right foot ☑
M21.6X2	Other acquired deformities of left foot ☑
M24.571	Contracture, right ankle ☑
M24.572	Contracture, left ankle ☑
Q66.01	Congenital talipes equinovarus, right foot ☑
Q66.02	Congenital talipes equinovarus, left foot ☑
Q66.6	Other congenital valgus deformities of feet
Q66.89	Other specified congenital deformities of feet

AMA: **27685** 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27685	6.69	12.21	0.93	19.83
27686	7.75	7.21	1.2	16.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
27685	6.69	6.55	0.93	14.17
27686	7.75	7.21	1.2	16.16

	FUD	Status	MUE	Modifiers				IOM Reference
27685	90	A	2(3)	51	50	62*	80	None
27686	90	A	3(3)	51	50	62*	N/A	

* with documentation

Terms To Know

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

contracture. Shortening of muscle or connective tissue.

incision. Act of cutting into tissue or an organ.

z-plasty. Plastic surgery technique used primarily to release tension or elongate contractured scar tissue in which a Z-shaped incision is made with the middle line of the Z crossing the area of greatest tension. The triangular flaps are then rotated so that they cross the incision line in the opposite direction, creating a reversed Z.

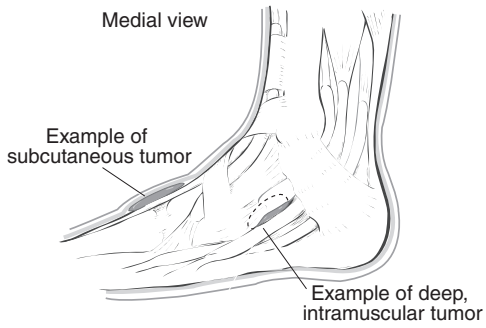
28043-28045 [28039, 28041]

28043 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm

28039 Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater

28045 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm

28041 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater



Explanation

The physician removes a tumor from the soft tissue of the foot or toe that is located in the subcutaneous tissue in 28039 and 28043 and in the deep soft tissue, below the fascial plane, or within the muscle in 28041 and 28045. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 28043 for excision of a subcutaneous tumor whose resected area is less than 1.5 cm and 28039 for a resected area that is 1.5 cm or greater. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28041 for a resected area 1.5 cm or greater.

Coding Tips

Subfascial tumors include those that involve tendons, tendon sheaths, or joints of a digit; tumors that are adjacent to but do not breach these areas are considered subcutaneous soft tissue tumors. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in these services. However, these procedures may be performed under general anesthesia, depending on the age and/or condition of the patient. Significant exploration of blood vessels, nerve repair, and complex repairs are reported separately. If a specimen is transported to an outside laboratory for handling or conveyance, see 99000. For radical resection of a tumor, soft tissue of foot, see 28046–28047. For excision of cutaneous, benign lesions, see 11420–11426.

ICD-10-CM Diagnostic Codes

C43.71 Malignant melanoma of right lower limb, including hip ☑

C47.21 Malignant neoplasm of peripheral nerves of right lower limb, including hip ☑

C49.21 Malignant neoplasm of connective and soft tissue of right lower limb, including hip ☑

C4A.71 Merkel cell carcinoma of right lower limb, including hip ☑

C76.51 Malignant neoplasm of right lower limb ☑

C7B.1 Secondary Merkel cell carcinoma

D03.71 Melanoma in situ of right lower limb, including hip ☑

D17.23 Benign lipomatous neoplasm of skin and subcutaneous tissue of right leg ☑

D21.21 Benign neoplasm of connective and other soft tissue of right lower limb, including hip ☑

D48.116 Desmoid tumor of lower extremity and pelvic girdle

D48.2 Neoplasm of uncertain behavior of peripheral nerves and autonomic nervous system

D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin

AMA: **28039** 2023,Aug; 2022,Oct; 2018,Sep **28041** 2023,Aug; 2022,Oct; 2018,Sep **28043** 2023,Aug; 2022,Oct; 2018,Sep **28045** 2023,Aug; 2022,Oct; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28043	3.96	7.16	0.39	11.51
28039	5.42	8.3	0.61	14.33
28045	5.45	8.45	0.52	14.42
28041	7.13	5.65	0.85	13.63

Facility RVU	Work	PE	MP	Total
28043	3.96	3.56	0.39	7.91
28039	5.42	4.2	0.61	10.23
28045	5.45	4.53	0.52	10.5
28041	7.13	5.65	0.85	13.63

	FUD	Status	MUE	Modifiers				IOM Reference
28043	90	A	4(3)	51	50	N/A	N/A	None
28039	90	A	2(3)	51	50	N/A	80	
28045	90	A	4(3)	51	50	N/A	80*	
28041	90	A	2(3)	51	50	N/A	80*	

* with documentation

Terms To Know

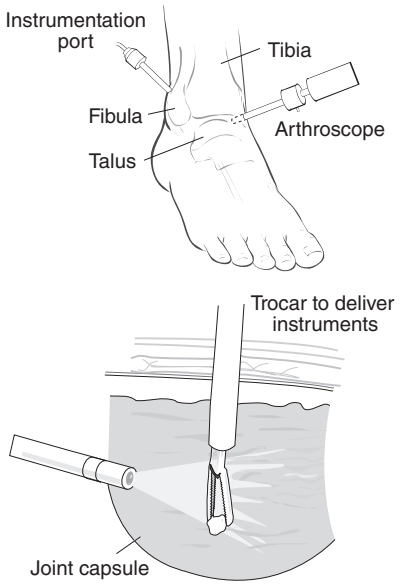
biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

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

29897-29898

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

29898 debridement, extensive



Schematic of removal of debris from capsule

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

G73.7 Myopathy in diseases classified elsewhere

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

M06.371 Rheumatoid nodule, right ankle and foot ☑

M06.871 Other specified rheumatoid arthritis, right ankle and foot ☑

M12.271 Villonodular synovitis (pigmented), right ankle and foot ☑

M12.571 Traumatic arthropathy, right ankle and foot ☑

M19.071 Primary osteoarthritis, right ankle and foot ☑

M24.171 Other articular cartilage disorders, right ankle ☑

M24.174 Other articular cartilage disorders, right foot ☑

M24.871 Other specific joint derangements of right ankle, not elsewhere classified ☑

M24.874 Other specific joint derangements of right foot, not elsewhere classified ☑

M31.7 Microscopic polyangiitis

M33.02 Juvenile dermatomyositis with myopathy

M33.12 Other dermatomyositis with myopathy

M65.871 Other synovitis and tenosynovitis, right ankle and foot ☑

M76.71 Peroneal tendinitis, right leg ☑

M77.51 Other enthesopathy of right foot and ankle ☑

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

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
29897	7.32	6.53	1.17	15.02
29898	8.49	7.23	1.24	16.96

Facility RVU	Work	PE	MP	Total
29897	7.32	6.53	1.17	15.02
29898	8.49	7.23	1.24	16.96

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

* with documentation

Terms To Know

arthroscopy. Use of an endoscope to examine the interior of a joint (diagnostic) or to perform surgery on joint structures (therapeutic).

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

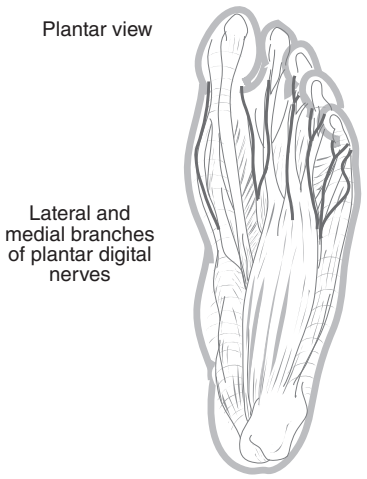
debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

osteochondritis dissecans. Avascular necrosis caused by lack of blood flow to the bone and cartilage of a joint causing the bone to die. This can result in splinters or pieces of cartilage breaking off in the joint.

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

64702-64704

64702 Neuroplasty; digital, 1 or both, same digit
64704 nerve of hand or foot



Explanation

In 64702, the physician releases a compressed nerve in a digit of the hand or foot. The physician makes an incision overlying the nerve. Surrounding tissues are dissected from the nerve freeing it from scar tissue or adhesions. The incision is repaired in layers. One or both of the digital nerves in a single finger or toe are decompressed. In 64704, a nerve in the hand or foot is decompressed.

Coding Tips

Report 64702 only once for each toe even if both digital nerves are released. Neuroplasty includes external neurolysis and transposition. Do not report 64702, 64704 with 11960. 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 internal neurolysis requiring use of an operating microscope, report 64727 in addition to the code for the primary procedure.

ICD-10-CM Diagnostic Codes

G56.31 Lesion of radial nerve, right upper limb ☑
G56.32 Lesion of radial nerve, left upper limb ☑
G57.51 Tarsal tunnel syndrome, right lower limb ☑
G57.52 Tarsal tunnel syndrome, left lower limb ☑
G57.61 Lesion of plantar nerve, right lower limb ☑
G57.62 Lesion of plantar nerve, left lower limb ☑
L90.5 Scar conditions and fibrosis of skin
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) ☑
Q70.21 Fused toes, right foot ☑
Q70.22 Fused toes, left foot ☑
Q70.23 Fused toes, bilateral ☑
Q70.31 Webbed toes, right foot ☑
Q70.32 Webbed toes, left foot ☑
Q70.33 Webbed toes, bilateral ☑
S94.01XA Injury of lateral plantar nerve, right leg, initial encounter ☑
S94.02XA Injury of lateral plantar nerve, left leg, initial encounter ☑
S94.11XA Injury of medial plantar nerve, right leg, initial encounter ☑
S94.12XA Injury of medial plantar nerve, left leg, initial encounter ☑
S94.21XA Injury of deep peroneal nerve at ankle and foot level, right leg, initial encounter ☑
S94.22XA Injury of deep peroneal nerve at ankle and foot level, left leg, initial encounter ☑
S94.31XA Injury of cutaneous sensory nerve at ankle and foot level, right leg, initial encounter ☑
S94.32XA Injury of cutaneous sensory nerve at ankle and foot level, left leg, initial encounter ☑
S94.8X1A Injury of other nerves at ankle and foot level, right leg, initial encounter ☑
S94.8X2A Injury of other nerves at ankle and foot level, left leg, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64702	6.26	8.27	1.14	15.67
64704	4.69	4.6	0.55	9.84
Facility RVU	**Work**	**PE**	**MP**	**Total**
64702	6.26	8.27	1.14	15.67
64704	4.69	4.6	0.55	9.84

	FUD	Status	MUE	Modifiers				IOM Reference
64702	90	A	2(3)	51	N/A	N/A	N/A	None
64704	90	A	4(3)	51	N/A	62*	80	

* with documentation

Terms To Know

contracture. Shortening of muscle or connective tissue.

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.

neuralgia. Sharp, shooting pains extending along one or more nerve pathways. Underlying causes may include nerve injury, diabetes, or viral complications.

tarsal tunnel syndrome. Entrapment or compression of the posterior tibial nerve, causing tingling, pain, and numbness in the sole of the foot.

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

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