Optum

Coding Companion

Podiatry

A comprehensive illustrated guide to coding and reimbursement

2025

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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.

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 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX .** Log in frequently to ensure you receive the most current updates.

Index

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

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

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

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

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

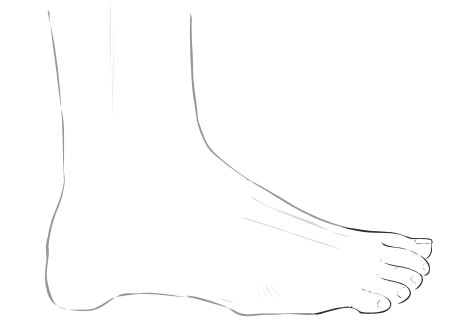
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

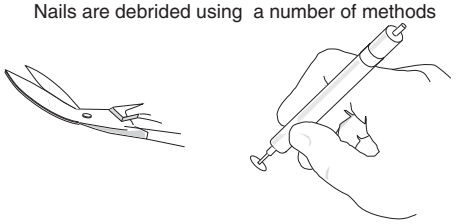
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

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	0.62	0.04	0.98
11721	0.54	0.74	0.04	1.32
Facility RVU	**Work**	**PE**	**MP**	**Total**
11720	0.32	0.07	0.04	0.43
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	100-02,15,290; 100-03,70.2.1
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 2024.

The following icons are used in *Coding Companion:*

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

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

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

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

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	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 the most common method of performing each procedure.

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

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

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

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

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

Relative Value Units

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

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

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

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

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

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

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

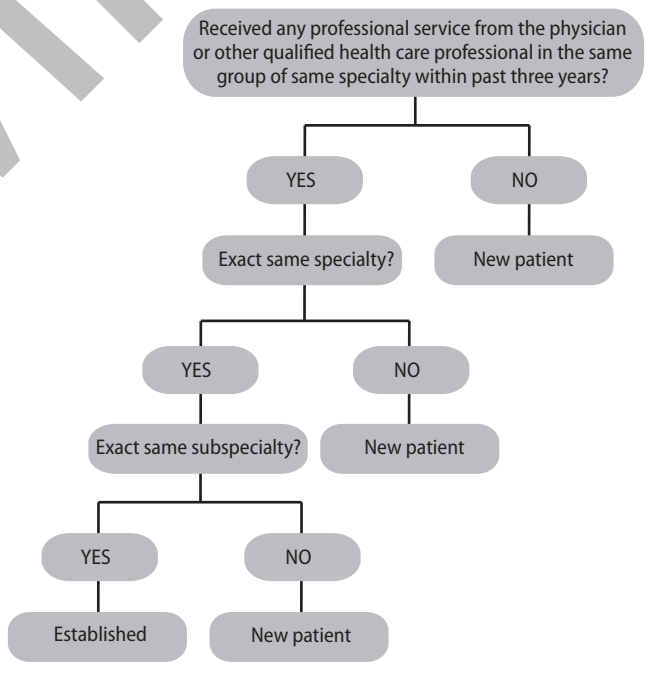
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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

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

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

Decision Tree for New vs Established Patients



Initial and Subsequent Services

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

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

▶ ◀ = Contains new or revised text

99202-99205

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

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

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

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

Explanation

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

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

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

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

Relative Value Units/Medicare Edits

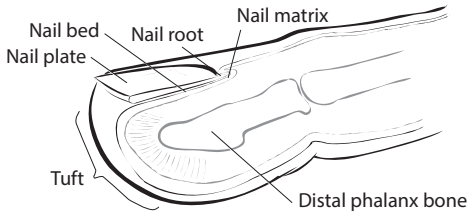
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

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

11750

11750 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;



A nail and its matrix are removed

Explanation

The physician removes all or part of a fingernail or toenail, including the nail plate and matrix permanently. The nail plate is bluntly dissected and lifted away from the nail bed. The nail plate is detached from the matrix using a scalpel. The matrix is destroyed using chemical ablation, CO2 laser, or electrocautery. The wound is dressed loosely.

Coding Tips

This procedure may be reported only once per digit. A partial excision of the nail does not count as two separate procedures, even when the partial excision requires two incisions (medial and lateral aspects). When a pinch graft is required, see 15050. 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 wedge excision of the skin of a nail fold (e.g., for ingrown toenail), see 11765. For avulsion of a nail plate, see 11730–11732. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

ICD-10-CM Diagnostic Codes

B35.1	Tinea unguium
L03.031	Cellulitis of right toe ☑
L03.032	Cellulitis of left toe ☑
L60.0	Ingrowing nail
L60.2	Onychogryphosis
L60.3	Nail dystrophy
L60.8	Other nail disorders
L62	Nail disorders in diseases classified elsewhere
Q84.5	Enlarged and hypertrophic nails
Q84.6	Other congenital malformations of nails

AMA: **11750** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

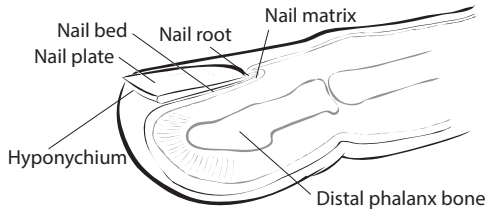
Non-Facility RVU	Work	PE	MP	Total
11750	1.58	3.07	0.12	4.77
Facility RVU	**Work**	**PE**	**MP**	**Total**
11750	1.58	1.29	0.12	2.99

	FUD	Status	MUE	Modifiers				IOM Reference
11750	10	A	6(3)	51	N/A	N/A	N/A	100-02,15,290; 100-03,70.2.1

* with documentation

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

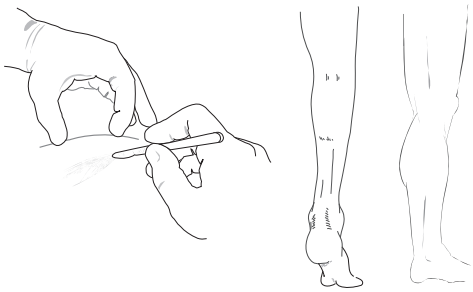
27618-27619 [27632, 27634]

27618 Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm

27632 Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater

27619 Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm

27634 Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater



A tumor is removed from the leg/ankle region

Explanation

The physician removes a tumor from the soft tissue of the leg or ankle area that is located in the subcutaneous tissue in 27618 and 27632 and in the deep soft tissue, below the fascial plane, or within the muscle in 27619 and 27634. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects 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 27618 for excision of a subcutaneous tumor whose resected area is less than 3 cm, and 27632 for a resected area 3 cm or greater. Report 27619 for excision of a subfascial or intramuscular tumor whose resected area is less than 5 cm, and 27634 for a resected area 5 cm or greater.

Coding Tips

An excisional biopsy is not reported separately when followed by an excisional removal during the same operative session. When 27618, 27632, 27619, or 27634 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. 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. For radical resection of a tumor of the soft tissue of the leg or ankle, see 27615–27616. For excision of cutaneous benign lesions, see 11400–11406.

ICD-10-CM Diagnostic Codes

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

C49.22 Malignant neoplasm of connective and soft tissue of left lower limb, including hip ☑

C79.89 Secondary malignant neoplasm of other specified sites

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

D17.24 Benign lipomatous neoplasm of skin and subcutaneous tissue of left leg ☑

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

D21.22 Benign neoplasm of connective and other soft tissue of left lower limb, including hip ☑

D48.116 Desmoid tumor of lower extremity and pelvic girdle

AMA: **27618** 2022,Oct; 2018,Sep **27619** 2022,Oct; 2018,Sep **27632** 2022,Oct; 2018,Sep **27634** 2022,Oct; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27618	3.96	10.0	0.74	14.7
27632	5.91	5.18	1.24	12.33
27619	6.91	6.0	1.15	14.06
27634	10.13	8.21	1.96	20.3
Facility RVU	**Work**	**PE**	**MP**	**Total**
27618	3.96	4.51	0.74	9.21
27632	5.91	5.18	1.24	12.33
27619	6.91	6.0	1.15	14.06
27634	10.13	8.21	1.96	20.3

	FUD	Status	MUE	Modifiers				IOM Reference
27618	90	A	3(3)	51	50	N/A	N/A	None
27632	90	A	3(3)	51	50	N/A	80	
27619	90	A	2(3)	51	50	N/A	N/A	
27634	90	A	2(3)	51	50	N/A	80	

* with documentation

Terms To Know

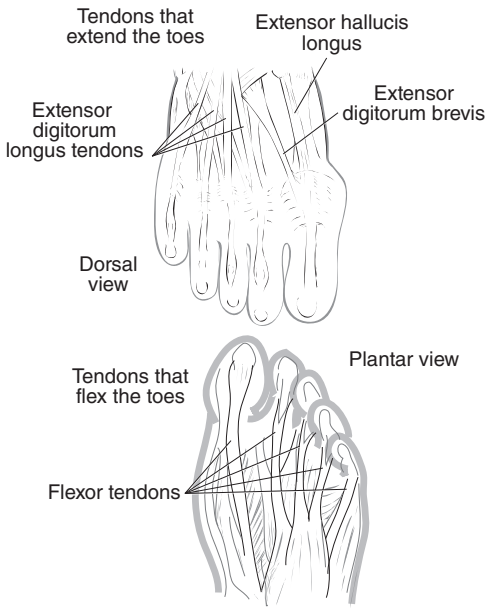
intramuscular. Within a muscle.

subcutaneous. Below the skin.

subfascial. Beneath the band of fibrous tissue that lies deep to the skin, encloses muscles, and separates their layers.

28010-28011

28010 Tenotomy, percutaneous, toe; single tendon
28011 multiple tendons



A percutaneous tenotomy is performed on a toe

Explanation

This procedure is performed to correct mallet or hammer toe. The physician makes a small incision at the crease of the toe where the tendon is restricted. The tendon is released from the bone and the toe is straightened. The incision is sutured and dressing applied. Report 28011 if more than one tendon is being straightened.

Coding Tips

For open tenotomy, see 28230–28234.

ICD-10-CM Diagnostic Codes

M20.11 Hallux valgus (acquired), right foot ☑
M20.12 Hallux valgus (acquired), left foot ☑
M20.21 Hallux rigidus, right foot ☑
M20.22 Hallux rigidus, left foot ☑
M20.31 Hallux varus (acquired), right foot ☑
M20.32 Hallux varus (acquired), left foot ☑
M20.41 Other hammer toe(s) (acquired), right foot ☑
M20.42 Other hammer toe(s) (acquired), left foot ☑
M20.5X1 Other deformities of toe(s) (acquired), right foot ☑
M20.5X2 Other deformities of toe(s) (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 ☑
Q66.89 Other specified congenital deformities of feet

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28010	2.97	3.74	0.25	6.96
28011	4.28	4.72	0.37	9.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
28010	2.97	2.97	0.25	6.19
28011	4.28	3.65	0.37	8.3

	FUD	Status	MUE	Modifiers				IOM Reference
28010	90	A	4(3)	51	N/A	N/A	N/A	None
28011	90	A	4(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

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.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

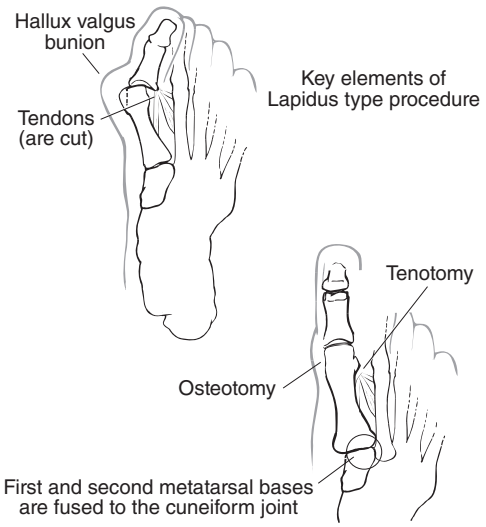
retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

tenotomy. Cutting into a tendon.

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

28297

▲ **28297** Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method



Explanation

The physician treats a bunion of the foot using any method in which the joint between the first metatarsal bone and medial cuneiform bone is fused (arthrodesis). The physician makes an incision in the skin between the first and second toes on the top of the foot. The incision is extended deep to the first metatarsophalangeal joint. The physician releases the contractured structures of the lateral joint. A second incision is made in the top of the foot over the medial metatarsocuneiform joint. The joint capsule is exposed and opened. The articular cartilage of the joint is removed. The ends of the bones are fashioned so they fit intimately together. The joint and bones of the big toe are manipulated into alignment. Fixation devices are needed to fuse the metatarsal and cuneiform bones. Prior to closing the incisions, the sesamoid bones are examined and removed as needed. The wounds are irrigated and closed in layers.

Coding Tips

To correct severe hallux valgus deformities, this procedure may be used in combination with other techniques. When used in combination with other methods (e.g., double osteotomy), see 28299. According to CPT guidelines, 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: **28297** 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
28297	9.29	20.28	1.11	30.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
28297	9.29	7.58	1.11	17.98

	FUD	Status	MUE	Modifiers				IOM Reference
28297	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

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

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

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.

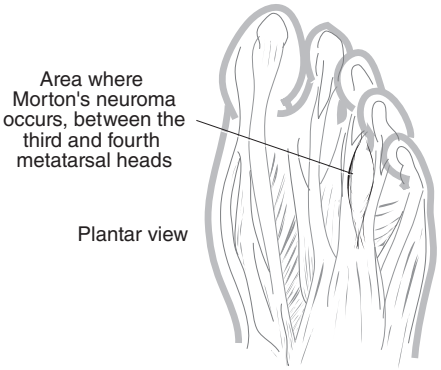
hallux valgus. Deformity in which the great toe deviates toward the other toes and may even be positioned over or under the second toe.

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.

64455

64455 Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)



Anesthetic and steroid is injected into the plantar common digital nerve or Morton's neuroma

Explanation

The physician injects a local anesthetic agent and/or steroid into a plantar common digital nerve from the dorsal direction. This procedure is often performed to treat Morton's neuroma, a frequently occurring injury of the forefoot that affects the third web space of the toes. This code reports single or multiple injections.

Coding Tips

Do not report 64455 with 64632. Imaging guidance is not included in this code and may be reported separately. For excision of a Morton's neuroma, see 28080.

ICD-10-CM Diagnostic Codes

G57.61 Lesion of plantar nerve, right lower limb ☑

G57.62 Lesion of plantar nerve, left lower limb ☑

G57.63 Lesion of plantar nerve, bilateral lower limbs ☑

AMA: **64455** 2023,Jan; 2022,Dec; 2021,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64455	0.75	0.67	0.06	1.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
64455	0.75	0.18	0.06	0.99

	FUD	Status	MUE	Modifiers				IOM Reference
64455	0	A	1(2)	51	50	N/A	80*	None

* with documentation

Terms To Know

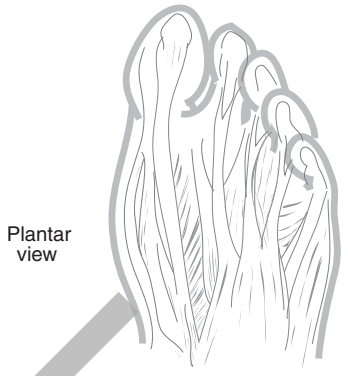
injection. Forcing a liquid substance into a body part such as a joint or muscle.

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.

Morton's neuroma. Painful lesion of the plantar nerve.

64632

64632 Destruction by neurolytic agent; plantar common digital nerve



Neurolytic agent is injected into the plantar common digital nerve

Explanation

This procedure is performed to treat chronic pain in the foot, most commonly used as a treatment for Morton's neuroma. The plantar nerve is destroyed using chemical, thermal, electrical, or radiofrequency techniques, which may be used independently or in combination. This procedure is designed to destroy the specific site(s) in the nerve root that produces the pain while leaving sensation intact. Generally intravenous conscious sedation is used during the initial phase of the procedure so that the patient can assist the physician in identifying the site of pain and the correct placement of the neurolytic agent, and local anesthesia is administered during the destruction phase of the procedure. Using separately reportable fluoroscopic guidance, a needle is inserted into the affected nerve root. An electrode is inserted through the needle and a mild electrical current is passed through the electrode. The current produces a tingling sensation at a site on the nerve. The electrode is manipulated until the tingling sensation is felt at the same site as the pain. Once the physician has determined that the electrode is positioned at the site responsible for the pain, a local anesthetic is administered and a neurolytic agent applied. Chemical destruction involves injection of a neurolytic substance (e.g., alcohol, phenol, glycerol) into the affected nerve root. Thermal techniques use heat. Electrical techniques use an electrical current. Radiofrequency, also referred to as radiofrequency rhizotomy, uses a solar or microwave current.

Coding Tips

For injection into plantar common digital nerves with anesthetics or steroids, see 64455. For neurectomy of the foot, see 28055.

ICD-10-CM Diagnostic Codes

G57.61 Lesion of plantar nerve, right lower limb ☑

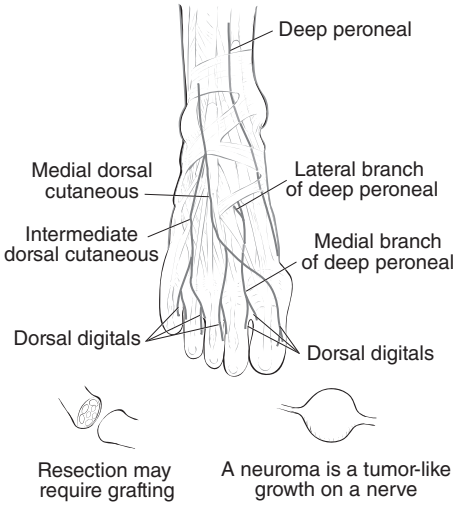
G57.62 Lesion of plantar nerve, left lower limb ☑

G57.63 Lesion of plantar nerve, bilateral lower limbs ☑

AMA: **64632** 2021,Feb; 2020,Dec; 2019,Apr; 2017,Oct; 2017,May

64774-64778

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



A neuroma is excised

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

D36.13 Benign neoplasm of peripheral nerves and autonomic nervous system of lower limb, including hip
D36.16 Benign neoplasm of peripheral nerves and autonomic nervous system of pelvis
G58.8 Other specified mononeuropathies
M79.604 Pain in right leg ☑
M79.605 Pain in left leg ☑
M79.661 Pain in right lower leg ☑
M79.662 Pain in left lower leg ☑
M79.671 Pain in right foot ☑
M79.672 Pain in left foot ☑
M79.674 Pain in right toe(s) ☑
M79.675 Pain in left toe(s) ☑
T87.33 Neuroma of amputation stump, right lower extremity ☑
T87.34 Neuroma of amputation stump, left lower extremity ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64774	5.8	5.93	1.11	12.84
64776	5.6	5.49	0.88	11.97
64778	3.11	1.61	0.64	5.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
64774	5.8	5.93	1.11	12.84
64776	5.6	5.49	0.88	11.97
64778	3.11	1.61	0.64	5.36

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

* with documentation

Terms To Know

cutaneous. Relating to the skin.

excision. Surgical removal of an organ or tissue.

incision. Act of cutting into tissue or an organ.

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

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

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	1.98	0.02	2.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0247	0.5	0.12	0.02	0.64

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

* with documentation

Terms To Know

atherosclerosis. Buildup of yellowish plaques composed of cholesterol and 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 ♂ Male Only ♀ Female Only

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

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

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