Podiatry
A comprehensive illustrated guide to coding and reimbursement

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*Coding Companion for Podiatry*
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 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 code is followed by its official CPT code description.

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

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

ICD-10-CM
Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information
One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

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

The codes in the appendix are presented in the following order:
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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

CCI Edit Updates
The Coding Companion series includes the list of codes from the official Centers for Medicare and Medicaid Services’ National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companion series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2021 edition password is: XXXXXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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

- 69501 Transmastoid antrotomy (simple mastoidectomy)
- 69501 Simple, Transmastoid

could be found in the index under the following main terms:
- Antrotomy
- Mastoid, Transmastoid
- Excision
- Simple, 69501

General Guidelines

Providers
The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under “Instructions for Use of the CPT Codebook” on page xii 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.
10060-10061

10060  Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

10061  complicated or multiple

A small incision is made to drain an abscess or cyst

Nail plate
Nail bed
Nail root
Nail matrix
Distal phalanx bone

Explanation
The physician makes a small incision through the skin overlying an abscess for incision and drainage (e.g., carbuncle, cyst, furuncle, paronychia, hidradenitis). The abscess or cyst is opened with a surgical instrument, allowing the contents to drain. The lesion may be curetted and irrigated. The physician leaves the surgical wound open to allow for continued drainage or the physician may place a Penrose latex drain or gauze strip packing to allow continued drainage. Report 10060 for incision and drainage of a simple or single abscess. Report 10061 for complex or multiple cysts. Complex or multiple cysts may require surgical closure at a later date.

Coding Tips
Local anesthesia is included in these services. For incision and drainage of a subfascial soft tissue abscess, see the appropriate incision and drainage for specific anatomical sites. For biopsy of skin, see 11102, 11104, or 11106.

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 puncture aspiration of an abscess, hematoma, bulla, or cyst, see 10160.

ICD-10-CM Diagnostic Codes
L02.415  Cutaneous abscess of right lower limb
L02.416  Cutaneous abscess of left lower limb
L02.425  Furuncle of right lower limb
L02.426  Furuncle of left lower limb
L02.435  Carbuncle of right lower limb
L02.436  Carbuncle of left lower limb
L02.611  Cutaneous abscess of right foot
L02.612  Cutaneous abscess of left foot
L02.621  Furuncle of right foot
L02.622  Furuncle of left foot
L02.631  Carbuncle of right foot
L02.632  Carbuncle of left foot
L02.818  Cutaneous abscess of other sites
L02.828  Furuncle of other sites
L02.838  Carbuncle of other sites
L03.031  Cellulitis of right toe
L03.032  Cellulitis of left toe
L03.042  Acute lymphangitis of left toe
L03.115  Cellulitis of right lower limb
L03.116  Cellulitis of left lower limb
L03.818  Cellulitis of other sites
L08.0  Pyoderma
L08.89  Other specified local infections of the skin and subcutaneous tissue
L98.0  Pyogenic granuloma

AMA: 10060 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11
10061 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

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Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.
furuncle. Inflamed, painful abscess, cyst, or nodule on the skin caused by bacteria, often Staphylococcus, entering along the hair follicle.
paronychia. Infection or cellulitis of nail structures.
28110  Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

Explanation
The physician makes a lateral incision over the distal third of the fifth metatarsal bone to expose the metatarsal head. An osteotome is used to remove the lateral extension of the bone (bunionette). The cut is made along the shaft of the bone. The wound is irrigated and the soft tissues are sutured. Soft dressing is applied and weight bearing is allowed as tolerated.

Coding Tips
This 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. 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
M21.621  Bunionette of right foot
M21.622  Bunionette of left foot
M21.6X1  Other acquired deformities of right foot
M21.6X2  Other acquired deformities of left foot
M25.774  Osteophyte, right foot
M25.775  Osteophyte, left foot
M84.871  Other disorders of continuity of bone, right ankle and foot
M84.872  Other disorders of continuity of bone, left ankle and foot
M89.371  Hypertrophy of bone, right ankle and foot
M89.372  Hypertrophy of bone, left ankle and foot
M89.8X7  Other specified disorders of bone, ankle and foot

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

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

exostosis. Abnormal formation of a benign bony growth.

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

ostectomy. Excision of bone.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.
99000

Handling and/or conveyance of specimen for transfer from the office to a laboratory

Explanation
This code is adjunct to basic services rendered. This code is reported for the handling and/or conveyance of a specimen from the provider’s office to a laboratory.

Relative Value Units/Medicare Edits

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99001

Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)

Explanation
This code is adjunct to basic services rendered. This code is reported for the handling and/or conveyance of a specimen from the patient in a location other than the provider’s office to the laboratory.

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99002

Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician or other qualified health care professional

Explanation
This code is adjunct to basic services rendered. The qualified provider reports this code for the handling conveyance, and/or any other service in connection with the implementation of an order involving devices such as orthotics, protectives, and prosthetics fabricated by an outside laboratory and fitted by the provider.

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99024

Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure

Explanation
The physician reports this code to indicate a postoperative follow-up visit, normally included in the surgical package when the physician performs an evaluation and management service for reason(s) that are related to the original procedure.

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99026-99027

Hospital mandated on call service; in-hospital, each hour

Out-of-hospital, each hour

Explanation
The code reports the time for hospital mandated on call service provided by the physician. This code does not include prolonged physician attendance time for standby services or the time spent performing other reportable procedures or services. Report 99026 for each hour of hospital mandated on call service spent in the hospital and 99027 for each hour of hospital mandated on call service spent outside the hospital.

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99050

Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

Explanation
This code is adjunct to basic services rendered. The physician reports this code to indicate services after posted office hours in addition to basic services.

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99051

Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

Explanation
This code is adjunct to basic services rendered. The physician reports this code to indicate services provided during posted evening, weekend, or holiday office hours in addition to basic services.