Hands-On
Cadaver Seminar
February 21-23, 2024
Celebration, Florida

Firm Up Your Surgical Foot Coding

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Academy of
Minimally Invasive
Foot & Ankle
Surgery

Conflict of Interest Disclosure

Michael G. Warshaw, DPM, CPC has no financial relationship with companies and/or products which could affect the objectivity of this lecture.

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Global Policy for Minor Surgeries (0 or 10 day Follow-up)

Any E/M service performed on the same day, as a Minor Surgery is included in the Surgery fee.
An initial (visit) E/M service (99201-99205, 99324-99328, 99281-99285) may be billed using the -25 Modifier on the E/M code.
ALL intra-operative services such as a local anesthesia, injections, dressings, casts, splints, **post-op shoes**, wires, pins, supplies, **etc**. that are a necessary part of a surgical procedure are included in the surgery fee.
Any and all medical and surgical services related to complications, which do not require a return to the operating room, are included in the surgery fee.
All post-op visits, during the 0 or 10 day follow-up period that are related to recovery from the surgery are included in the surgery fee.
Any post-op pain management services directly related to the surgery are included in the surgery fee.
All hospital admission and discharge reports, including the surgeon's H & P are included in the surgery fee.
Any anesthesia (local, regional, and general) provided by the surgeon are included in the surgery fee.
You may bill for any pre-operative consultations by a non-surgeon.
You may bill for any surgical procedure that requires a return to the operating room (use Modifier -78 on the surgical code).
You may bill for any post-op injectable drugs (**materials only**) by using the appropriate J code. Bill to MAC.
You may bill for any splint or casting supplies used post-op by using the Q codes as appropriate. Bill to MAC.
You may bill for any devices for fractures or dislocations used post-op (ie CAM WALKER) by using the appropriate L code. Bill to DMERC.

Global Policy for Major Surgeries (90 day Follow-up)

The preoperative visit on the same day or one day prior to the day of surgery is included in the surgery fee.
An initial (visit) E/M service (99201-99205, 99324-99328, 99281-99285) may be billed using the -57 Modifier on the E/M code.
You may bill a separately identifiable procedure on the same day by using the -57 Modifier on the E/M code.
For a major surgery, you may use the -57 Modifier to bill for the service to decide to perform the surgery, if it occurs the day before or day of major surgery. If the decision to perform surgery is made at the time of a consultation, you may bill the E/M code with the -57 Modifier.
All intra-operative services such as local anesthesia, injections, dressings, casts, splints, **post-op shoes**, wires, pins, supplies, **etc**. that are a necessary part of a surgical procedure are included in the surgery fee.
Any and all medical and surgical services related to complications, which do not require a return to the operating room, are included in the surgery fee.
All post-op visits during the 90 day follow-up period that are related to recovery from the surgery are included in the surgery fee.
Any post-op pain management services directly related to the surgery are included in the surgery fee.
All hospital admission and discharge reports, including the surgeon's H & P are included in the surgery fee.
Any anesthesia (local, regional, and general) provided by the surgeon are included in the surgery fee.
You may bill for any surgical procedure that requires a return to the operating room (use Modifier -78 on the surgical code).
You may bill for any post-op injectable drugs (**material only**) by using the appropriate J code. Bill to MAC.
You may bill for any splint or casting supplies used post-op by using the Q codes as appropriate. Bill to MAC.
You may bill for any devices for fractures or dislocations used post-op (ie. CAM WALKER) by using the appropriate L codes. Bill to DMERC.

Post-Operative Global Periods

Major Surgery
Any CPT code that has a Global Period of "90" days is classified as a Major Surgical Procedure.

Minor Surgery
Any CPT code that has a Global Period of "0" or "10" days is classified as a Minor Surgical Procedure.

Why can't they mean what they say?

- Even though the Global Periods are stated as "0," "10," or "90" days, in reality they are "1," "11," and "92" days
- For a Global Period of "0," the Global Period includes the day that the procedure is actually performed. Thus, in reality, "0" really means "1."
- For a Global Period of "10," the Global Period includes the actual day that the procedure is performed and the next 10 consecutive postoperative days. Thus, in reality, "10" really means "11."
- For a Global Period of "90," the Global Period includes the actual day that the procedure was performed, the day BEFORE the procedure was performed, AND the next 90 consecutive postoperative days. Thus, in reality, "90" really means "92."

Surgical Dressings

Surgical dressings are necessary for the treatment of wounds or lesions. They are classified as either PRIMARY or SECONDARY dressings.

PRIMARY dressings are therapeutic or protective dressings applied directly to the wound or lesion.

SECONDARY dressings are utilized to secure the PRIMARY dressing to the wound or lesion, that is the "surgical site" (Examples: adhesive tape, roll gauze, badges, DISPOSABLE COMPRESSION MATERIAL) (Examples of what is NOT considered to be a secondary dressing: elastic stockings, support hose, foot coverings, surgical leggings, pressure garments, etc.)

Surgical dressings that are applied by the physician are INCLUDED as part of the professional service, that is, they are INCLUDED in the CPT code that was performed and billed for by the physician.

Surgical dressings obtained by the patient to perform home care, if PRESCRIBED by a physician may be covered. If they are covered, they are billed to the DME Regional Carrier.

*You MUST establish whether or not the dressing that you are providing for home care is covered by DMERC. If it is covered by DMERC and you DO NOT have a DMERC number, you CANNOT charge the patient for the supply You MUST give the patient a prescription so that they can obtain the supply from another source.

*You MUST be aware of the LCD for surgical dressings as published by your DME Regional Carrier.

*You MUST be aware of the HCPCS LEVEL II description of the surgical supplies that you are providing or supplying.

Common Podiatric Procedures:

Incision and Drainage

Code Quick Reference: 10060 10120 10140 10160 10061

Assistant Surgeon	Not Covered
Follow-up days	10 days

Code Description:

10060	I & D of abscess (cutaneous or subcutaneous abscess, cyst, or paronychia) simple or single
10061	I & D abscess (cutaneous or subcutaneous abscess, cyst, or paronychia) complicated or multiple
10120	Incision and removal of foreign body, subcutaneous tissue, simple
10121	Incision and removal of foreign body, subcutaneous tissue, complicated
10140	Incision and drainage of hematoma, seroma or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst

Important Notes:

These and similar Minor Procedures (10 day follow-up) usually require adequate Medical Necessity justification. (i.e., C&S, path report, etc.). Inappropriate use of these codes is scrutinized by CMS.

Correct Coding Edits:

These following codes will not be paid if billed with Procedure Code 10060							
11055	11056	11057	11719	11720	11721	11730	11740
11765	20500	64450	69990	97597	97598	97602	97605
97606	G0127						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10061							
10060	11055	11056	11057	11719	11720	11721	11730
11740	11750	11760	11765	20500	29580	29581	64450
69990	97597	97598	G0127				
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10120							
11055	11056	11057	11719	11720	11721	G0127	
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10121							
10120	11720	11721	64450				
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10140							
11055	11056	11057	11719	11720	11721	29580	29581
64450	G0127						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. – LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with Procedure Code 10160							
11055	11056	11057	11719	11720	11721	29580	29581
64450							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

Documentation for I&D Procedures
(CPT codes 10060, 10061)

1. A through description of the abscess
    a. Exact location
    b. Size of the abscess
    c. Signs
    d. Symptoms
2. Culture and Sensitivity
3. Astringent soaks
4. At least a topical antibiotic (after all, this IS an infection)
5. For a complicated I&D, additional documentation is needed:
    a. Local anesthesia
    b. Oral antibiotic
    c. Separate op report
6. The patient needs to be seen 1 time post operatively WITHIN the 10 day global period

ICD-10 Codes

- L03.115 Cellulitis of right lower limb
- L03.116 Cellulitis of left lower limb
- L02.611 Cutaneous abscess of right foot
- L02.612 Cutaneous abscess of left foot
- *L03.031 Cellulitis of right toe(s)
- *L03.032 Cellulitis of left toe(s)

– *ICD-9 cross walk for paronychia

Treatment of Wart/Verruca

17110 17111

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	10 days

Code Description:

17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
17111	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions.

Important Notes:

The 11420 code series (11420, 11421, 11422, 11423, 11424, 11426) can be appropriate for the surgical excision of a wart/benign lesion. Excision is defined as a full thickness (through the dermis) removal of the lesion including simple closure. A pathology report and op report may be needed, particularly for larger or multiple lesions. Code selection: measuring greatest clinical diameter of a lesion plus margin required for complete excision.

	See below for the most appropriate ICD-10 codes that qualify 17110,
	17111 and the 11420 series of codes for reimbursement. Please access
	your MAC's LCD for more specific coding information.

Correct Coding Edits:

These following codes will not be paid if billed with procedure code 17110							
11100	11719	11900	11901	17000	64450	69990	97597
97598	97602	97605	G0127				
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with procedure code 17111							
11057	11100	11900	11901	17000	17110	64450	69990
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

ICD-10 Code for 17110, 17111 **B07.0 Verruca plantaris**

ICD-10 Code for 11420, etc. **D23.71 Other benign neoplasm of right lower limb, including hip**

D23.72 Other benign neoplasm of left lower limb, including hip

Nail Procedures

11730 11732 11750 11752 11760 11765

NOTE: CPT Codes 11730 and 11750 are targeted for fraud and abuse by CMS.

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	0 days (11730, 11732) 10 days (11750, 11752, 11760, 11765)

Code Description:

11730	Avulsion of nail plate, partial or complete
11732	Avulsion each additional nail plate (use in conjunction with 11730)
11750	Excision of nail and nail matrix, partial or complete, for permanent removal
11752	Excision of nail and nail matrix, partial or complete, for permanent removal , with amputation of tuft of distal phalanx (subungal exostectomy)
11760	Repair of nail bed
11765	Wedge excision of skin of nail fold (e.g., for ingrown toenail)

Important Notes: 11730/11732

Code 11730 is used for partial or complete avulsions of a nail plate. **Every** Medicare Carrier requires that your medical records indicate that **digital anesthesia** was administered and follow-up care was performed. A partial or complete avulsion is payable to a maximum of 1 x per toe. **Digital anesthesia** entails the use of an **INJECTION** of local anesthetic fluid.

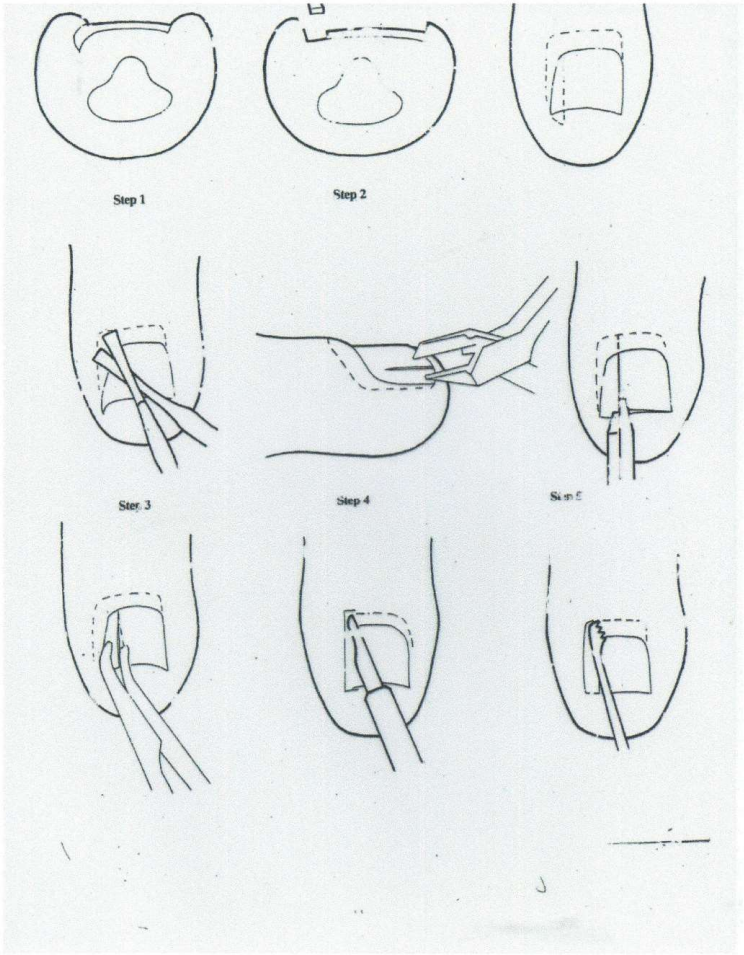
Important Notes: 11750/11752

A partial or complete matrixectomy is payable to a maximum of one per toe using 11750. This can entail one border, both borders or the entire toenail. The matrixectomy plus the removal of a subungal exostosis can be billed with 11752.

Correct Coding Edits:

These following codes will not be paid if billed with procedure code 11730							
10160	11000	11719	11720	11721	11740	11755	11765
11900	11901	17250	29440	29450	29515	29550	29580
29581	64450	69990	97597	97598	97602	97605	G0127
G0168							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with procedure code 11750							
10060	11000	11042	11055	11056	11057	11719	11720
11721	11730	11740	11755	11760	11765	11900	11901
13131	15852	17250	20550	20551	20552	20553	24900
29450	29515	29540	29550	29580	29581	64450	69990
G0127	G0168						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							


Step 1
Step 2
Step 3
Step 4

Nail Procedures

11730 11732 11750 11752 11760 11765

NOTE: CPT Codes 11730 and 11750 are targeted for fraud and abuse by CMS.

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	0 days (11730, 11732) 10 days (11750, 11752, 11760, 11765)

Code Description:

11730	Avulsion of nail plate, partial or complete
11732	Avulsion each additional nail plate (use in conjunction with 11730)
11750	Excision of nail and nail matrix, partial or complete, for permanent removal
11752	Excision of nail and nail matrix, partial or complete, for permanent removal , with amputation of tuft of distal phalanx (subungal exostectomy)
11760	Repair of nail bed
11765	Wedge excision of skin of nail fold (e.g., for ingrown toenail)

Important Notes: 11730/11732

Code 11730 is used for partial or complete avulsions of a nail plate. **Every** Medicare Carrier requires that your medical records indicate that **digital anesthesia** was administered and follow-up care was performed. A partial or complete avulsion is payable to a maximum of 1 x per toe. **Digital anesthesia** entails the use of an **INJECTION** of local anesthetic fluid.

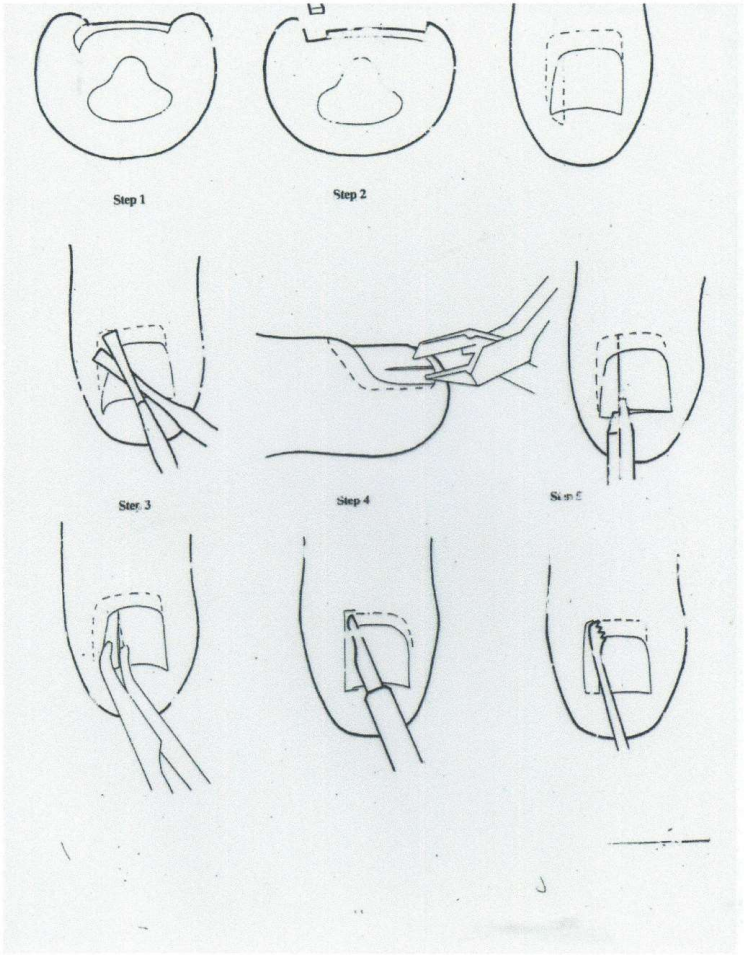
Important Notes: 11750/11752

A partial or complete matrixectomy is payable to a maximum of one per toe using 11750. This can entail one border, both borders or the entire toenail. The matrixectomy plus the removal of a subungal exostosis can be billed with 11752.

Correct Coding Edits:

These following codes will not be paid if billed with procedure code 11730							
10160	11000	11719	11720	11721	11740	11755	11765
11900	11901	17250	29440	29450	29515	29550	29580
29581	64450	69990	97597	97598	97602	97605	G0127
G0168							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with procedure code 11750							
10060	11000	11042	11055	11056	11057	11719	11720
11721	11730	11740	11755	11760	11765	11900	11901
13131	15852	17250	20550	20551	20552	20553	24900
29450	29515	29540	29550	29580	29581	64450	69990
G0127	G0168						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							


Step 1
Step 2
Step 3
Step 4

These following codes will not be paid if billed with procedure code 11752							
10060	10061	11000	11042	11720	11721	11730	11740
1750	11755	11760	11765	11900	11901	12032	13131
17250	20550	20551	20552	20552	29440	29450	29515
29540	29550	29580	64450	69990	97597	97598	97602
97605	97606						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with procedure code 11760							
10060	11000			11042	11720	11721	11730
11740	11755	11762	11900	11901	12001	12002	12004
12005	12041	12042	12044	12047	13131	13132	17250
20550	20551	20552	20553	29440	29450	29515	29540
29550	29580	64450	69990	97597	97598	97602	97605
97606	G0168						
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These following codes will not be paid if billed with procedure code 11765							
11056	11057	11740	11755	11900	11901	13131	17250
20550	20551	20552	20553	29440	29450	29515	29540
29550	29580	64450	69990	97597	97598	97602	97605
97606							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

ICD-10 CODES FOR 11730:
L03.031 Cellulitis of right toe
L03.032 Cellulitis of left toe
The above 2 codes are also the codes for paronychia.

ICD-10 CODES for 11750:

L60.0	Ingrowing nail
M79.674	Pain in the right toe(s)
M79.675	Pain in the left toe (s)

Note: It would be most appropriate for L60.0 to be the primary diagnosis with either M79.674 and M79.675 to be the secondary diagnosis.

CPT code 11755

- It is amazing to me how often this CPT code is misused and abused.
- There seems to be a common denominator among a number of providers. They look at the numbers and don't read the words. What do I mean by this?
- The CPT code is accessed and then it is determined what this particular CPT code reimburses when it is billed. The definition or description of the CPT code is either ignored, glossed over or "interpreted."
- CPT description or definition of 11755 is the following:

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

There is nothing within this definition to indicate that obtaining "nail clippings" and submitting them to pathology demonstrates that a "biopsy of a nail unit" was performed and it is appropriate to bill CPT code 11755.

CPT Assistant, October, 2004

- The article states that CPT code 11755 "is not intended to be reported when obtaining nail clippings or nail scrapings for purposes of performing a fungal culture, KOH preparation, stain or test, or PAS stain.
- These activities are part of an evaluation and management visit involving the medical management of the nail condition.
- When medically appropriate, nail trimming and/or nail debridement services should be indicated with the specific codes."

What is the biopsy of a nail unit?

- When you look at the CPT description, it appears to be quite inclusive.
- Once again in order to obtain clarity, CPT Assistant needs to be accessed

CPT Assistant, December 2002

- The article states that "The nail plate and nail bed may be biopsied using one of several techniques.
- A small punch may be used to obtain a tissue sample. The punch is placed on the nail plate and pushed down through the plate and into the nail bed. The punch is removed and the specimen is gently pried out of the hole with a small needle and then cut out with scissors.
- For larger biopsies, a longitudinal incision is made over the affected area with a scalpel and extended down to the periosteum. The specimen is removed and the wound is closed with sutures.
- When the nail matrix is biopsied, short longitudinal incisions may be made on either side of the proximal nail fold in line with the lateral nail folds. The tissue is elevated and lifted off the proximal nail plate, a portion of which is removed for access to the nail matrix. A punch or scalpel is used to remove the biopsy specimen. The wound is closed with sutures."

By the way, if the toenail is avulsed to gain access to the targeted area, CPT code 11730 is a Column 2 code to CPT code 11755 the Column 1 code within the CCI edits and is not separately reimbursable.

Updates Regarding CPT codes 11730 and 11750

First, let's take a look at the rules that were put into place on June 6, 2022, by CMS/Medicare with respect to CPT 11730 and CPT 11750:
The rule changes are the following: Sources of information – L33833 – Surgical Treatment of Nails, A57666 – Billing and Coding: Surgical Treatment of Nails
Utilization Parameters
1. CPT 11730 and CPT 11732 for nail avulsion will be denied if billed for the same finger less than 4 months (16 weeks) or the same toe less than 8 months (32 weeks) following a previous avulsion.
2. CPT 11750 for nail excision permanent removal will be denied if billed for the same finger or toe following a previous excision.
3. A medically reasonable and necessary repeat avulsion or excision of the same nail within 32 weeks of a previous avulsion, or excision, of the same nail, will be considered upon redetermination. The medical record must support the service, for example, there is an ingrown nail of the opposite border or a new significant pathology on the same border recently treated.

Documentation Requirements
1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The following information must be clearly documented in the patient's medical record:
o Complete detailed description of the pre-operative findings. Include the patient's symptoms, the physical examination documenting the severity of the nail infection, injury or deformity, and the assessment and plan containing the rationale why surgical treatment is being selected over other treatment options.
o Method of obtaining anesthesia (if not used, the reason for not using it).
o A complete detailed description of the procedure performed.
o Identify the specific digit(s) and make note to the nail margin(s) involved on which the procedure was performed.
o Postoperative observation and treatment of the surgical site (e.g., minimal bleeding, sterile dressing applied).
o Postoperative instructions given to the patient and any follow-up care (e.g., soaks, antibiotics, follow-up appointments).

This has the potential to be a major pain in the butt. However, CMS has modified its new policy regarding specifically CPT 11750, Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal. Two of the Medicare Administrative Carriers, First Coast Service Options and Novitas have modified and updated their respective LCDs and the associated articles for Coding and Billing for the Surgical Treatment of Nails. A rejected claim for CPT 11750 no longer needs to be resubmitted to the Medicare Administrative Carrier for Redetermination. Providers have been instructed to append modifier KX for a medically reasonable and necessary repeat nail excision (CPT 11750) on the same toe. The KX modifier is defined as the following: DOCUMENTATION ON FILE – Use this Medicare modifier to indicate that specific documentation is contained in the medical record in order to justify the billed service. In this situation, the medical record must be specific as to the indication, such as ingrown nail of the opposite border or new significant pathology on

the same border recently treated. The documentation requirements are posted above. The use of the KX modifier only applies to CPT 11750.

I would follow these guidelines for CPT code 11750 whether the subsequent matrixectomy was performed within 32 weeks or was performed after a longer period of time. Since performing a matrixectomy long after 32 weeks seems more justifiable than a matrixectomy that was performed in a time frame sooner than 32 weeks, I would follow the same guidelines and use the FX modifier and not use an ABN.

With respect to CPT 11730 and CPT 11732, A medically reasonable and necessary repeat CPT 11730 / CPT 11732 of the same nail within 32 weeks of a previous avulsion will be considered upon Redetermination. The use of the KX modifier does not apply to repeat procedures/billing of CPT 11730 and CPT 11732. If the avulsion is performed on the opposite nail border or is there is new significant pathology on the same nail border that is specifically documented within the medical record, this would justify going through the Redetermination process.

An Advanced Beneficiary Notice of Non-coverage (ABN) is really not needed as long as the justification for performing the repeat procedure meets the guidelines as stated above.

Tenotomies of Toes

28010 28011 28230 28232 28234

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	90 days

Code Description:

28010	Tenotomy, percutaneous, toe; single tendon
28011	Tenotomy, percutaneous, toe; multiple tendons
28230	Tenotomy, open, tendon, flexor; foot, single or multiple tendon(s) (separate procedure)
28232	Tenotomy, open tendon flexor; toe, single tendon (separate procedure)
28234	Tenotomy, open extensor, foot or toe, each tendon

Important Notes:

Multiple procedures performed on a single digit are usually considered a Hammertoe correction and payable to a maximum 28285 code value.

Correct Coding Edits:

These codes will not be paid if billed with procedure code 28010							
11055	20550	20551	20552	20553	29425	29540	64450
64455	69990						
If one of these procedure codes is performed on a separate toe, food, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These codes will not be paid if billed with procedure code 28011							
20550	20551	20552	20553	28010	29540	64450	64455
69990							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These codes will not be paid if billed with procedure code 28230 OR 28232							
20550	20551	20552	20553	29345	29355	29405	29425
29505	29515	29540	64450	64455	69990		
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

These codes will not be paid if billed with procedure code 28234							
20500	20550	20551	20552	20553	28010	28011	29345
29355	29405	29425	29505	29515	29540	64450	64455
69990							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

Digital Surgery

28108 28124 28270 28272 28285 28286 28310 28312

Code Quick Reference:

Assistant Surgeon	Not Covered
Follow-up days	90 days

Code Description:

28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot
28124	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); phalanx of toe
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)
28272	Capsulotomy; interphalangeal joint, each joint (separate procedure)
28285	Correction, hammertoe (eg. interphalangeal fusion, partial or total phalangectomy, arthroplasty)
28286	Correction, cocked-up fifth toe, with plastic skin closure (e.g., Ruiz-Mora type procedure)
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	Osteotomy, shortening, angular or rotational correction; other phalanges, any toe

Important Notes:

Multiple procedures performed on a single digit are usually considered a Hammertoe correction and payable to a maximum 28285 code value.

A Hammertoe Correction:

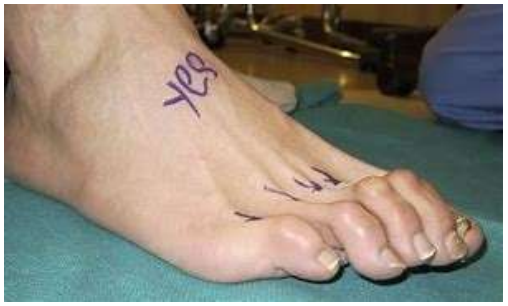
May include an excision of a portion of bone, with or without fusion or fixation of the digit, with or without a k-wire or any other mode of internal fixation.
Includes all skin and soft tissue corrections, repairs, incisions, or excision at the interphalangeal joints or metatarsal phalangeal joint.
Multiple exostectomies performed at the same time on the same toe are considered incidental and are included in the reimbursement for a hammertoe.
A matrix correction done in addition to the hammertoe correction is usually payable at 50% of the primary procedure code. This is an example of two unrelated procedures performed on same toe, same date of service.
Code 14040 is usually not considered appropriate for de-rotation of the 5th toe. Most carriers will pay this procedure as 28285 or 28286.
Insertion of an interphalangeal implant into toes 2-5 is considered included in the 28285 reimbursement.

Correct Coding Edits:

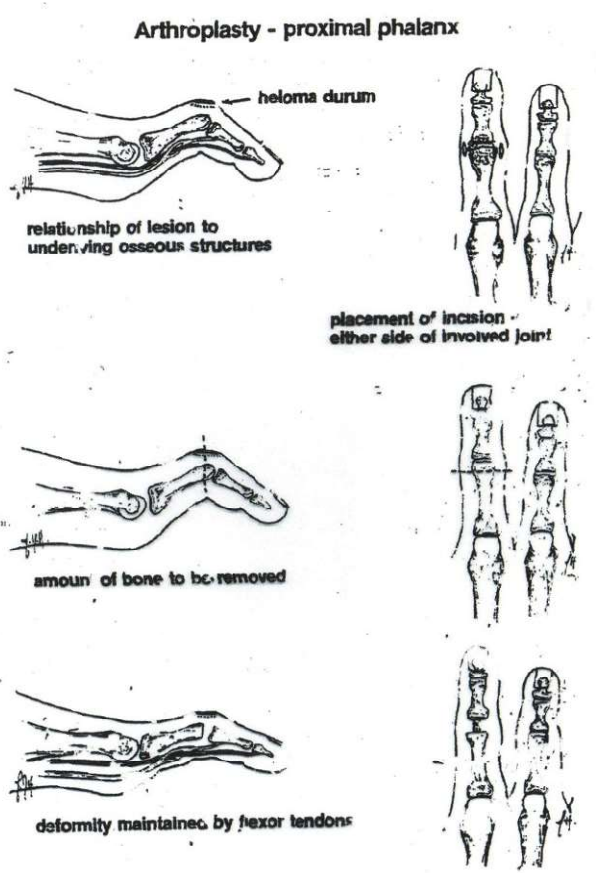
These codes will not be paid if billed with procedure code 28108							
10060	10140	10160	20005	20220	20240	20550	20551
20552	20553	20615	28024	28054	28124	28190	28192
28193	28234	28286	28312	29540	29550	64450	64455
69990							
If one of these procedure codes is performed on a separate toe, foot, or site, use the appropriate Anatomic Modifier (i.e. –LT, -RT, -TA, -T1, etc.) to notify Medicare that is should be paid.							

Hammertoe – CPT 28285

A hammertoe correction may include an excision of a portion of bone, with or without fusion of fixation of the digit, with or without a K-wire or any other mode of internal fixation.

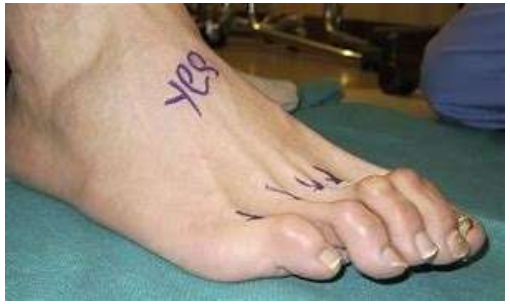


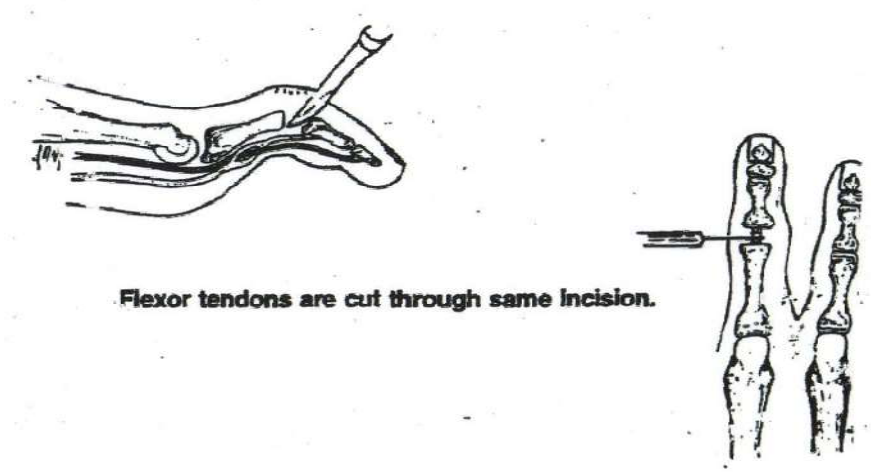
ICD-10-CM Codes
M20.41: Other hammertoe(s) (acquired), right foot
M20.42: Other hammertoe(s) (acquired), left foot



Hammertoe – CPT 28285

A hammertoe correction includes all skin and soft tissue corrections, repairs, incisions, or excision at the interphalangeal joints or metatarsophalangeal joint.



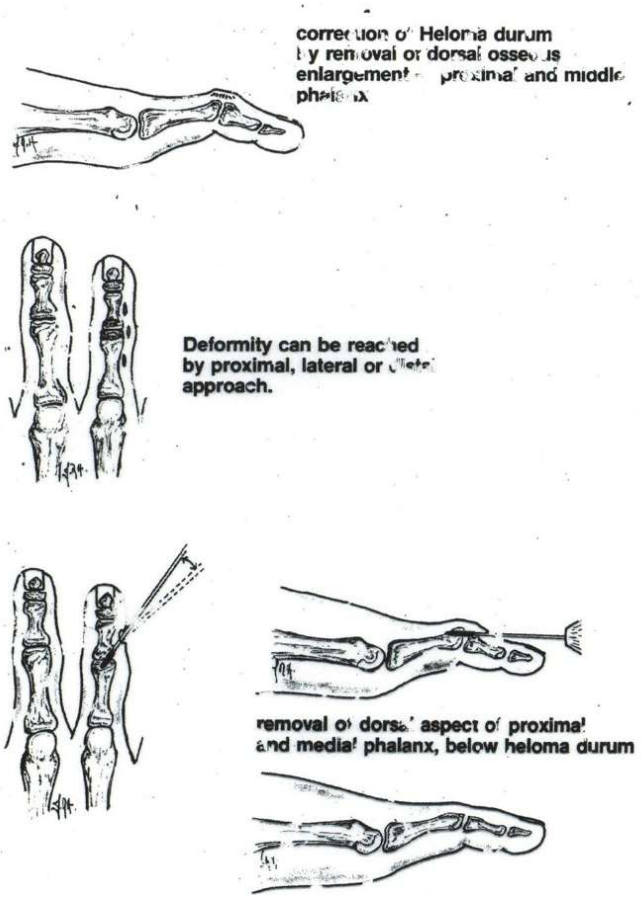


Flexor tendons are cut through same incision.

With tendons cut, complete reduction of deformity is possible.

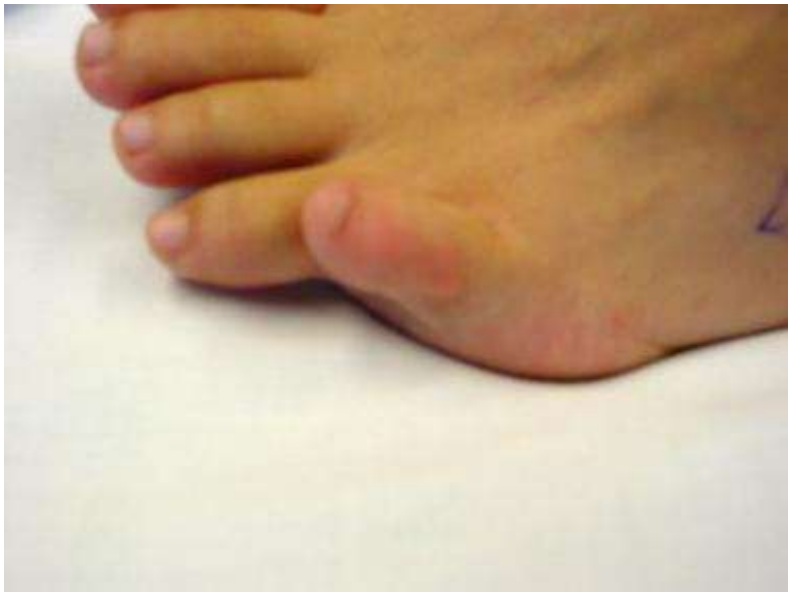
Hammertoe – CPT 28285

Multiple exostectomies performed at the same time on the same toe are considered incidental and are included in the reimbursement for a hammertoe.



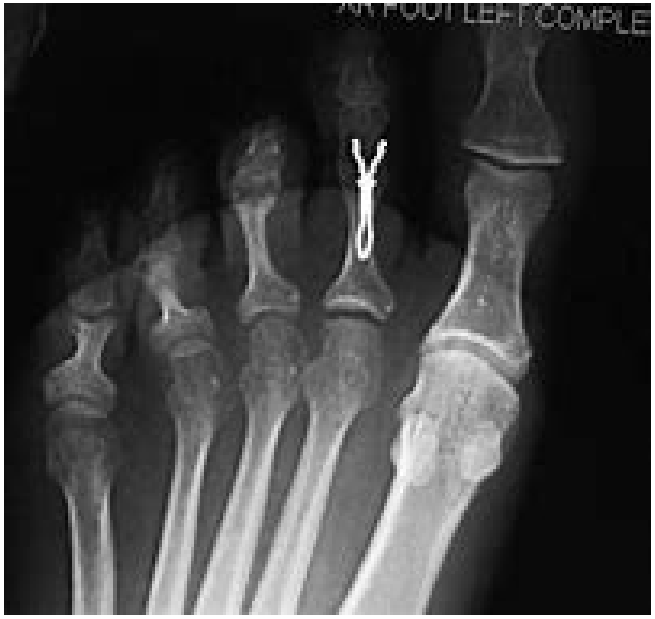
Hammertoe

CPT code 14040 (Adjacent tissue transfer or rearrangement, feet; defect 10 sq. cm or less) is usually not considered appropriate for de-rotation of the 5th toe. Most carriers will pay this procedure as 28285 or 28286.



Hammertoe

Insertion of an interphalangeal implant into toes 2-5 is considered included in the reimbursement for CPT code 28285.



First MPJ Procedures

28289 28291 28292 28295 28296 28297 28298 28299 28315

Code Quick Reference:

Assistant Surgeon	Covered except for 28290 and 28315
Follow-up days	90 days

Code Description: ICD-10 codes for Hallux rigidus: M20.21 Hallux rigidus, right foot; M20.22 Hallux rigidus, left foot
ICD-10 codes for Hallux valgus: M20.11 Hallux valgus, right foot; M20.12 Hallux valgus, left foot

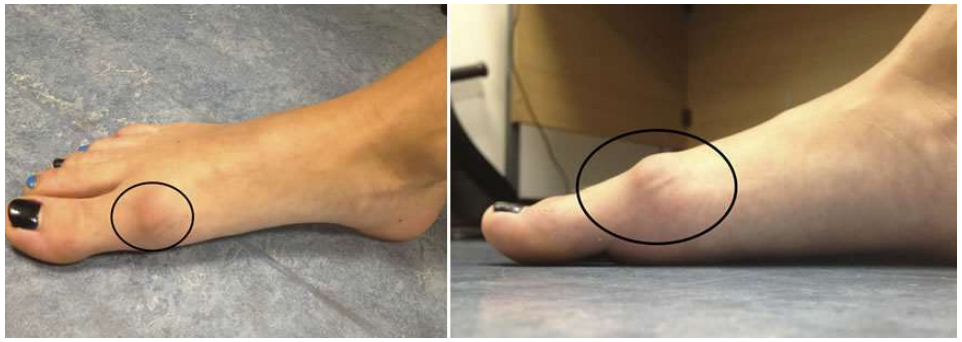
28289	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291	Hallux rigidus correction, with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant
28292	Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed. with resection of proximal phalangeal base, when performed, any method
28295	Correction, hallux valgus [bunionectomy], with sesamoidectomy when performed, with proximal metatarsal osteotomy, any method
28296	Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with distal metatarsal osteotomy, any method
28297	Correction, hallux valgus [bunionectomy], with sesamoidectomy; when performed, with first metatarsal and medial cuneiform arthrodesis, any method
28298	Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with proximal phalanx osteotomy, any method
28299	Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with double osteotomy, any method
28315	Sesamoidectomy, first toe (separate procedure)

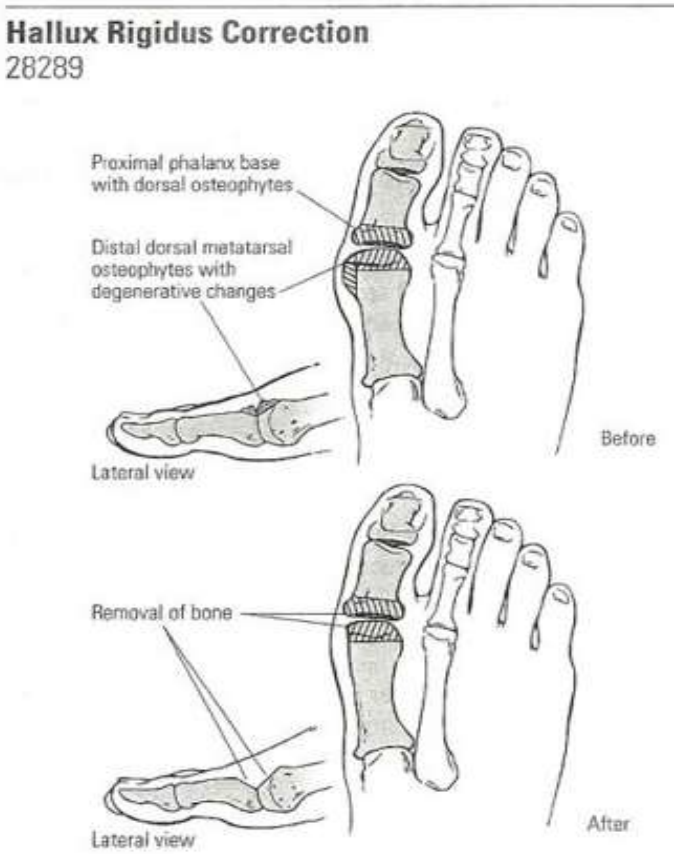
Important Notes:

A bunion correction includes those collective procedures that constitute a total correction. The "Correct Coding Edits" list all the individual procedure codes considered included in a specified bunionectomy. Medicare will not pay for them if billed with the specified bunion code.
28315 if performed as a single procedure is appropriate for a total or partial sesamoidectomy

CPT Code 28289

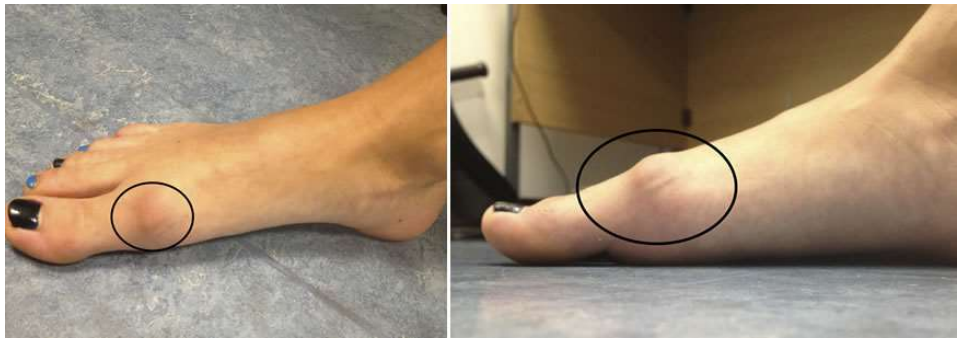
Hallux Rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant.

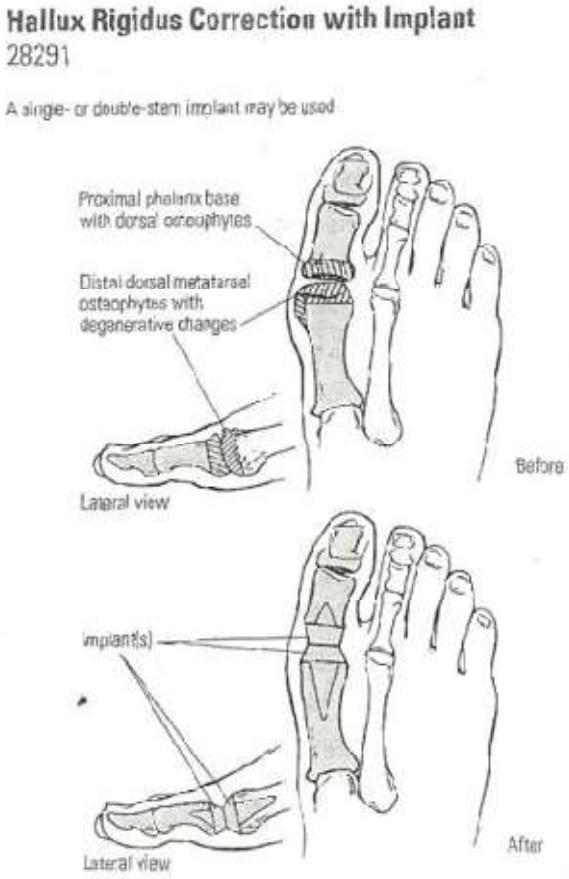




CPT Code 28291

Hallux rigidus correction, with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant.





BUNIONECTOMY”
CPT 28292, 28295, 28296, 28297, 28298, and 28299

Prior to 1-1-24:

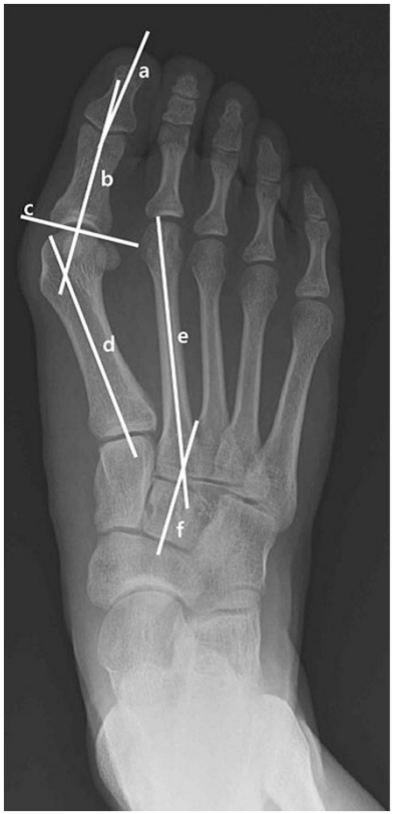
Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed…

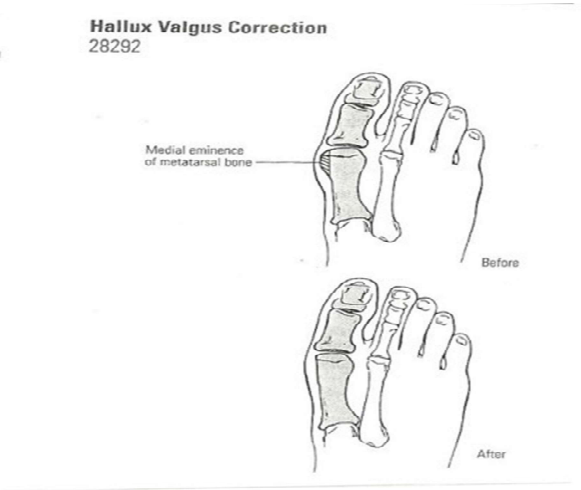
Starting 1-1-24:

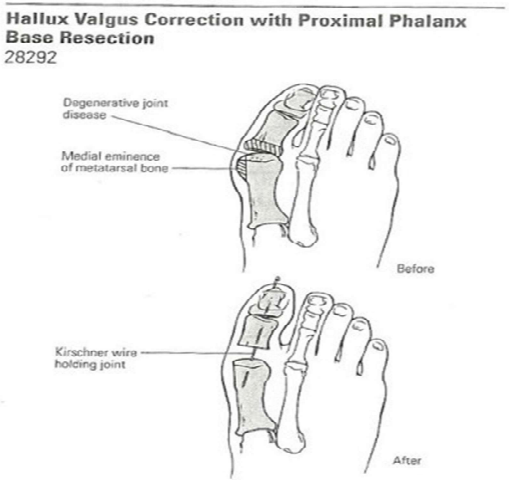
Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed…

CPT Code 28292

Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed, with resection of proximal phalangeal base, when performed, any method.

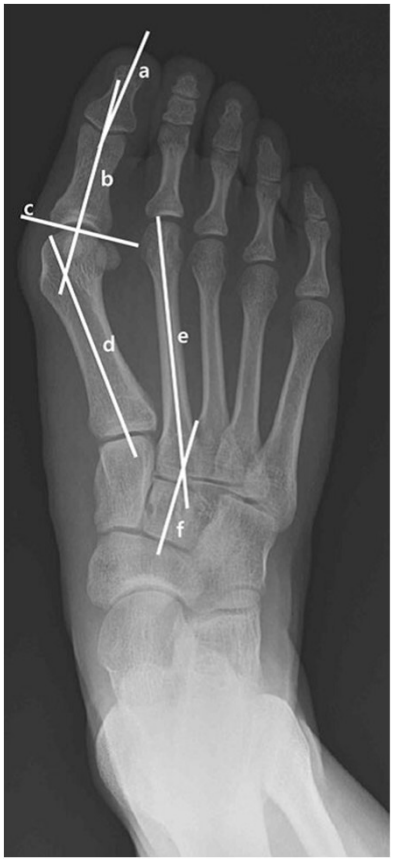


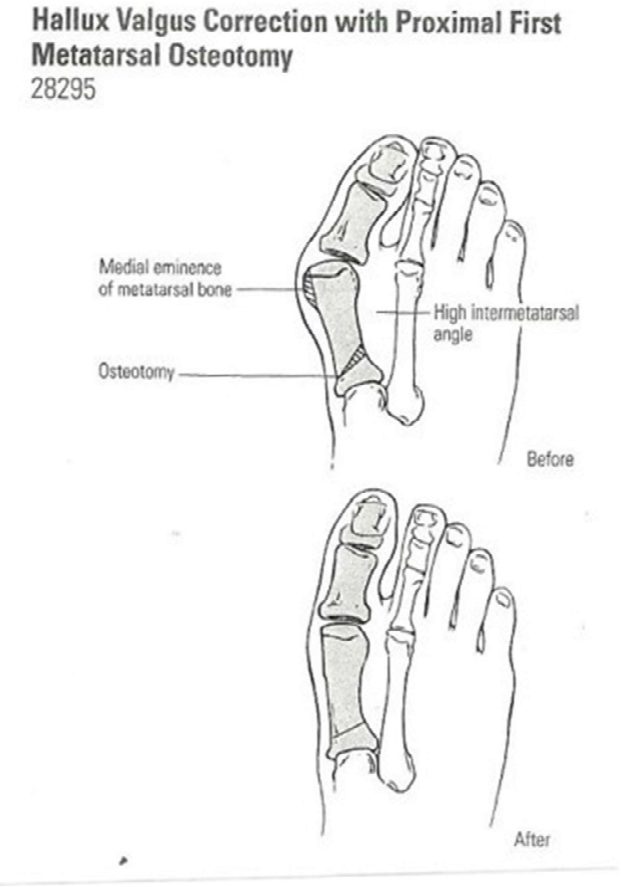




CPT Code 28295

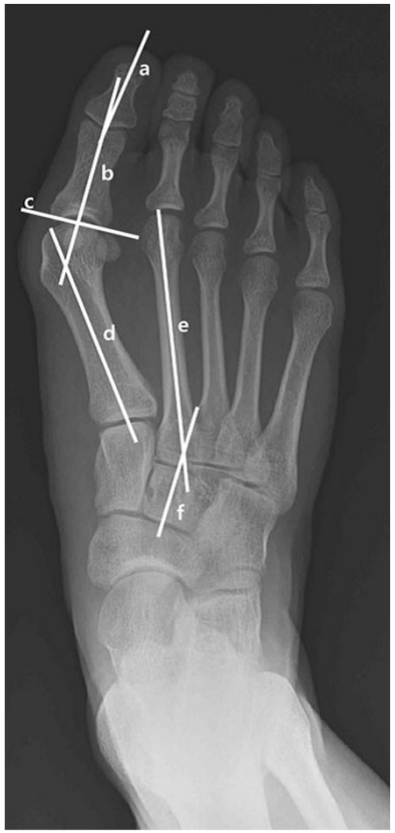
Correction, hallux valgus [bunionectomy], with sesamoidectomy when performed, with proximal metatarsal osteotomy, any method.

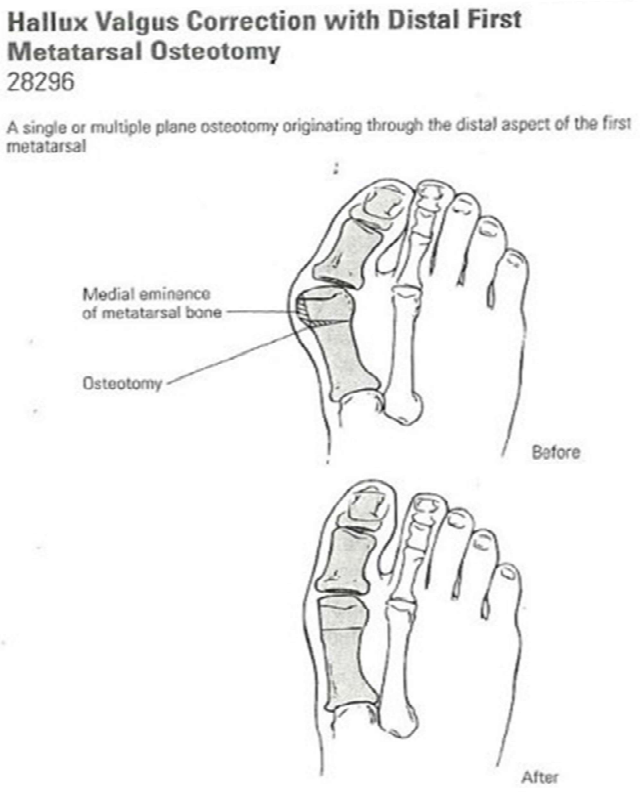




CPT Code 28296

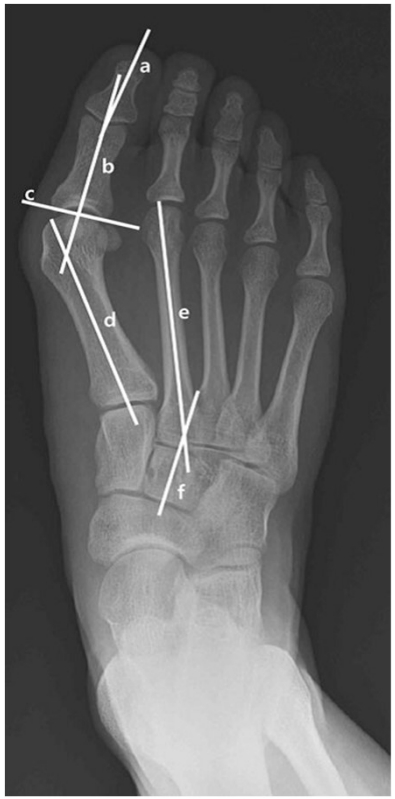
Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with distal metatarsal osteotomy, any method

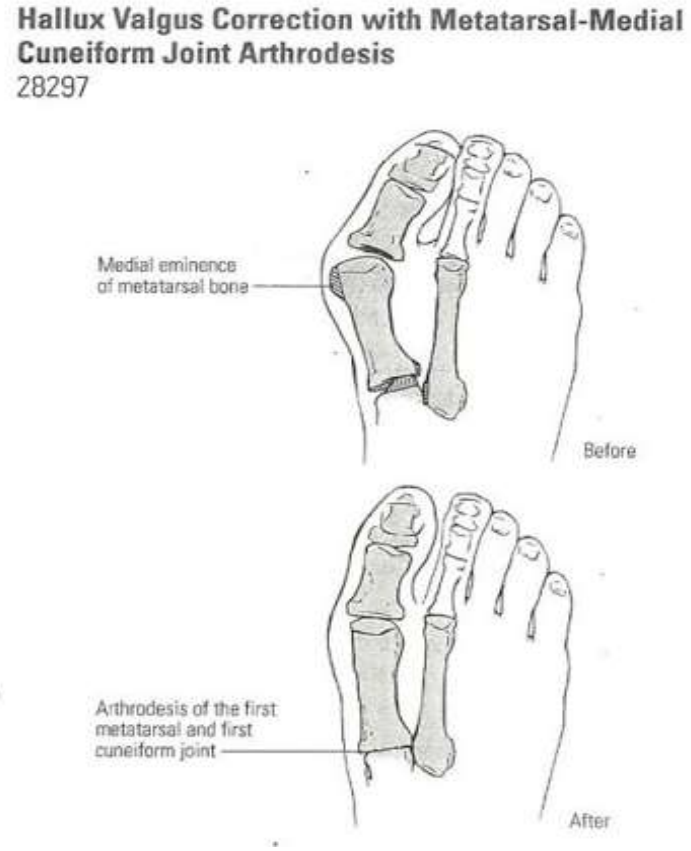




CPT Code 28297

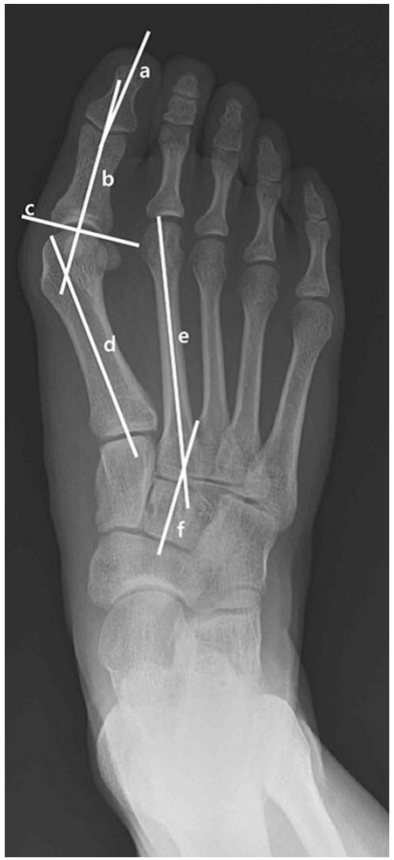
Correction, hallux valgus [bunionectomy], with sesamoidectomy; when performed, with first metatarsal and medial cuneiform arthrodesis, any method

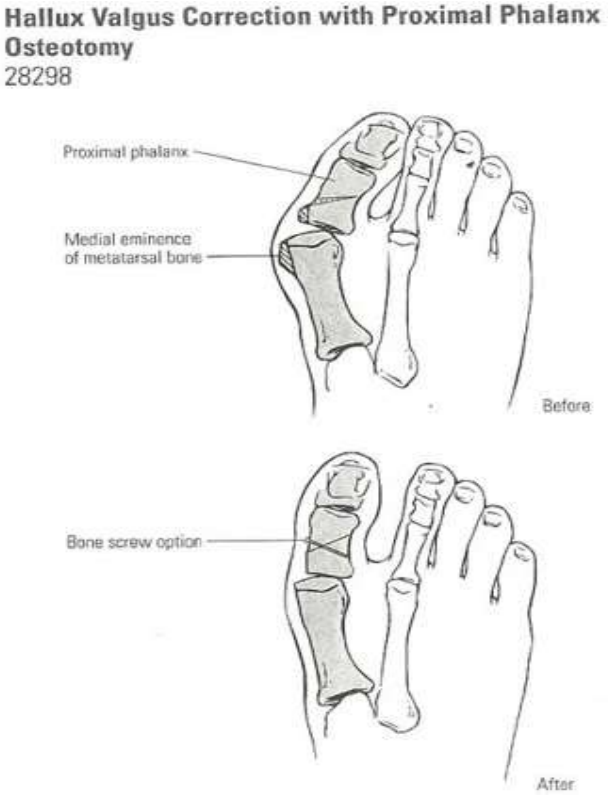




CPT Code 28298

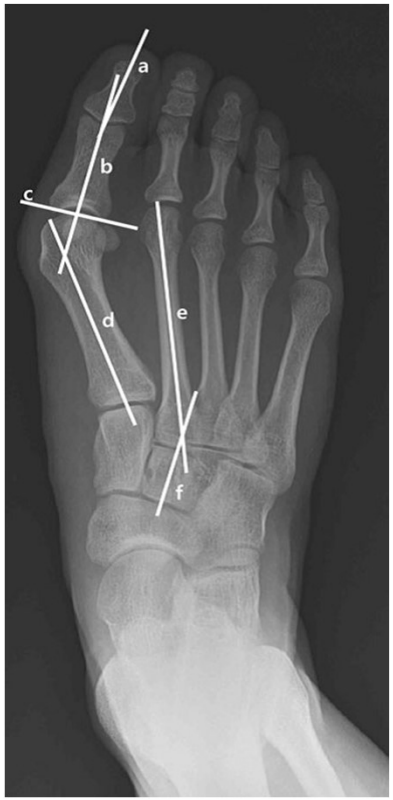
Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with proximal phalanx osteotomy, any method

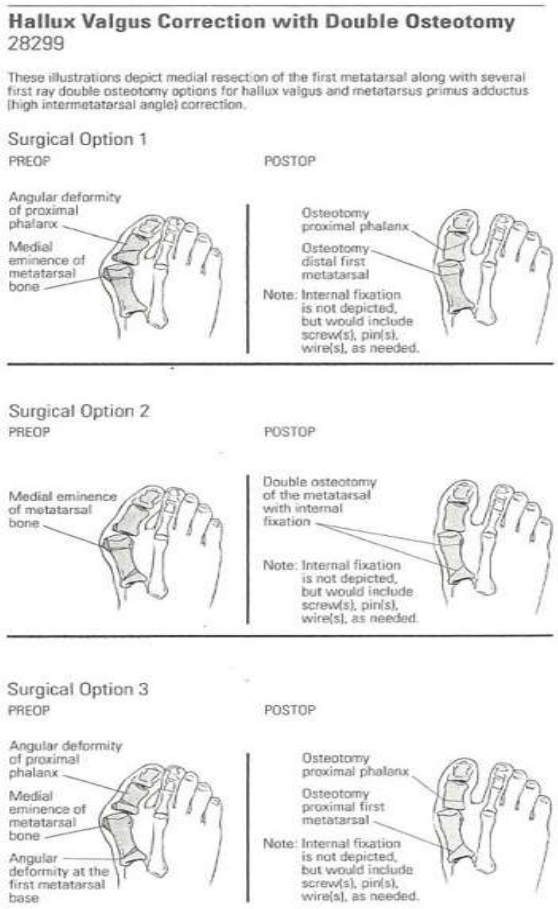




CPT Code 28299

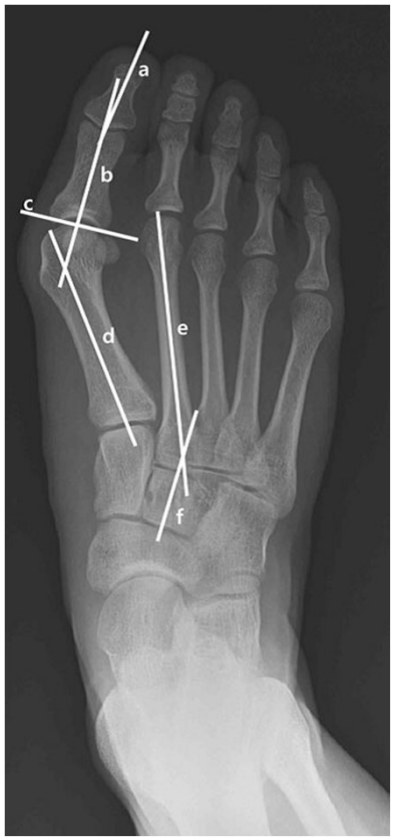
Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with double osteotomy, any method

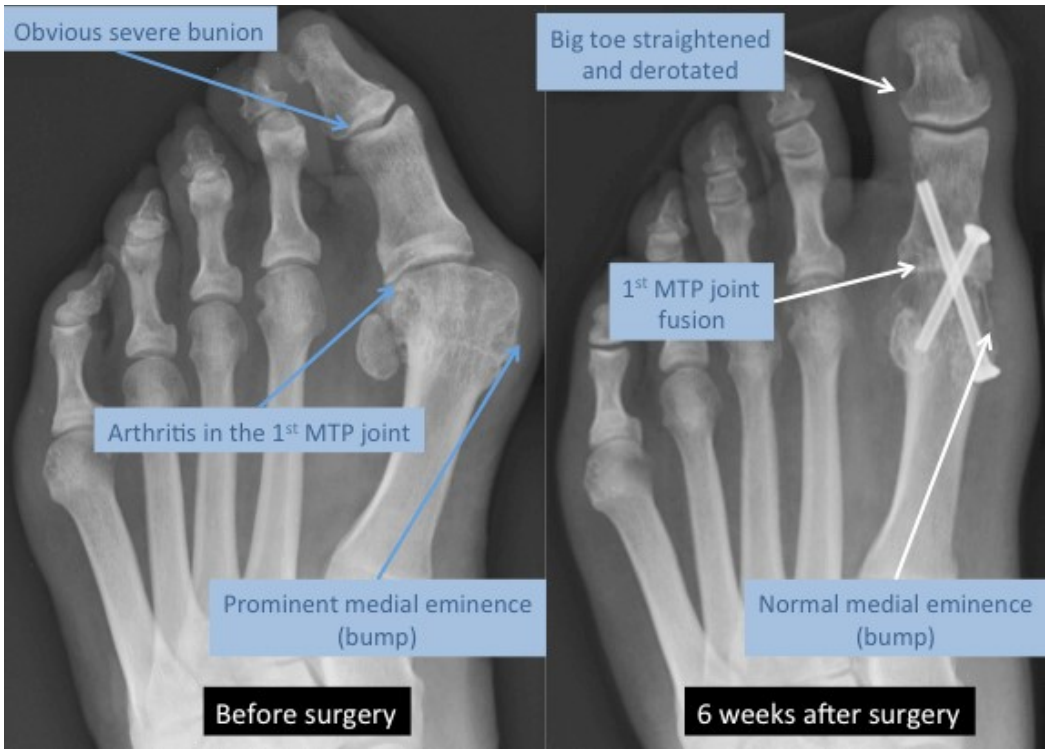




Additional Hallux Valgus Correction Procedure to Consider: CPT Code 28750

Arthrodesis, Great Toe; Metatarsophalangeal Joint



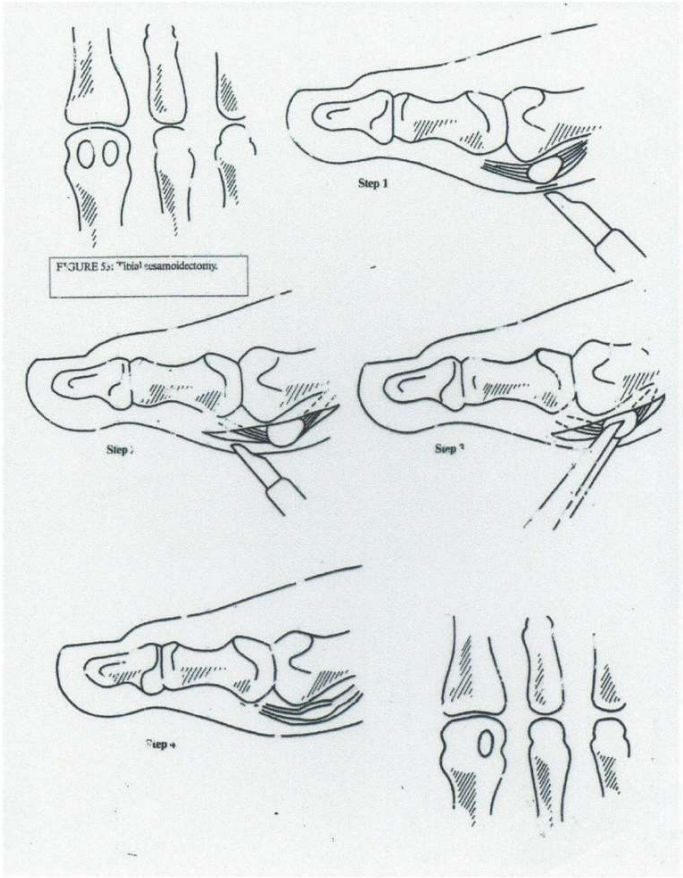


CPT Code 28750 (cont.)

- **It should be noted that based upon the CCI edits, if an arthrodesis/fusion at the 1st MPJ (CPT Code 28750) is performed in conjunction with the removal of the medial eminence from the head of the 1st metatarsal (CPT Code 28292), both CPT codes can be billed on the same date of service. They are NOT bundled.**

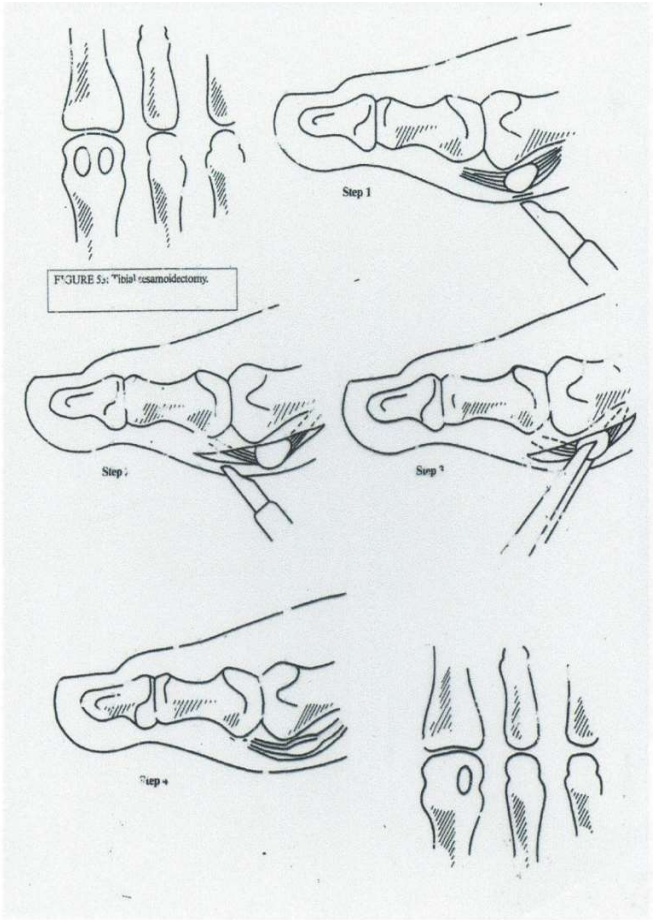
CPT Code 28315

Sesamoidectomy, first toe (separate procedure)



CPT Code 28315 (cont.)

Sesamoidectomy, first toe (separate procedure)



- ICD-10-CM codes for sesamoiditis

  M25.871: Other specified disorders, right ankle and foot

  M25.872: Other specified disorders, left ankle and foot

CPT Code 28080

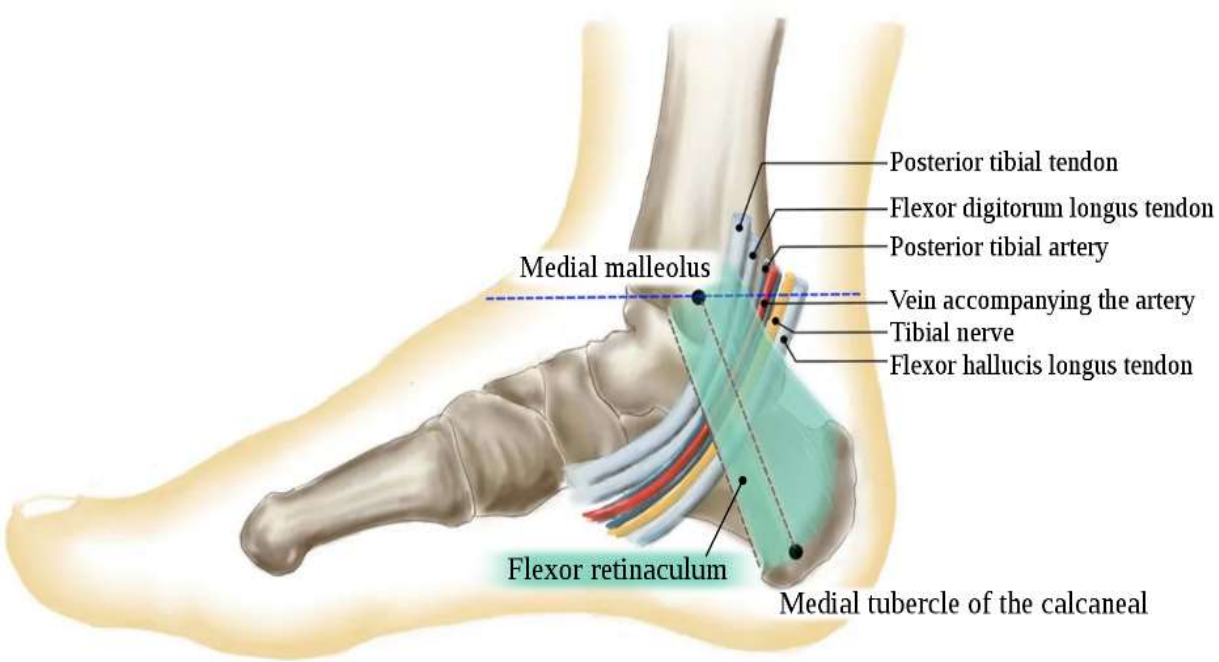
Excision Interdigital (Morton) neuroma, each

- The use of CPT Code 64782 (Excision of neuroma; hand or foot, except digital nerve) is usually not considered appropriate for these procedures.
- CPT code 64782 is the appropriate CPT code to use for the excision of a “non-Morton’s neuroma.”

ICD-10-CM Codes for Morton’s Neuroma:

- G57.61: Lesion of plantar nerve, right lower limb
- G57.62: Lesion of plantar nerve, left lower limb

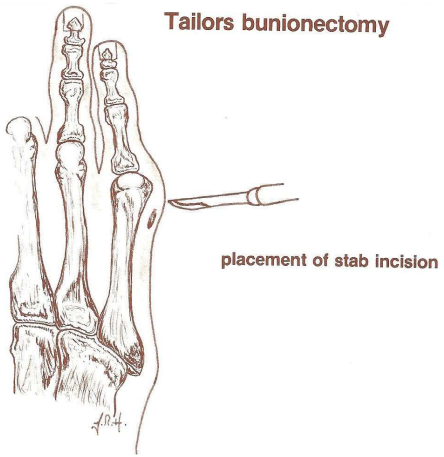
CPT Code 28035

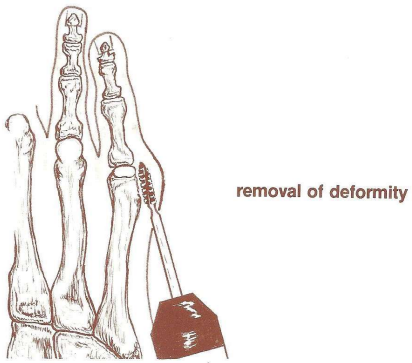


- 28035 Release, tarsal tunnel (posterior tibial nerve decompression)

CPT Code 28110

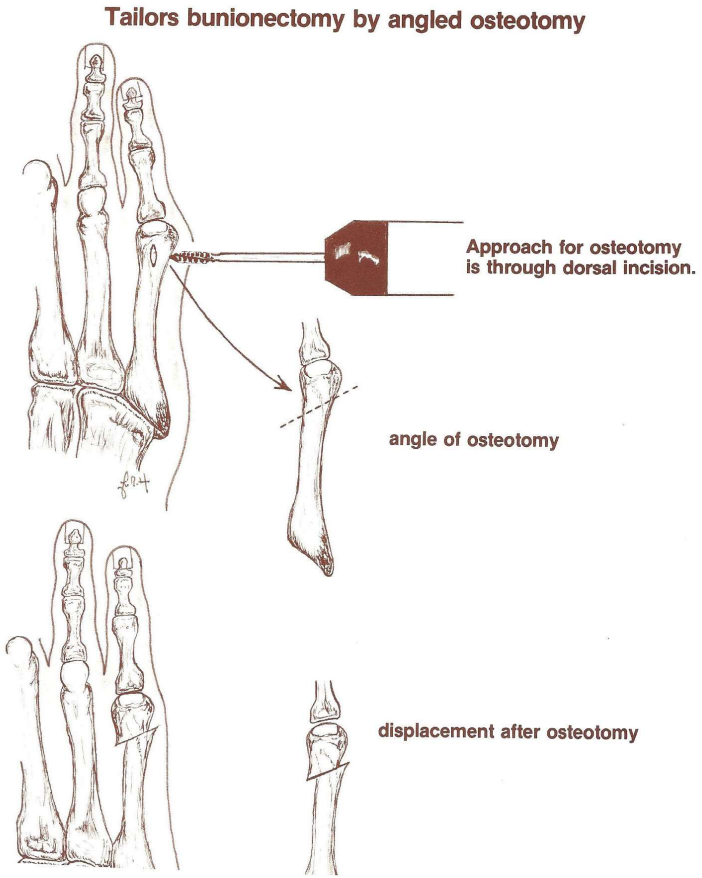
Ostectomy, partial excision, fifth metatarsal head (aka Tailor's bunionectomy)





- ICD-10-CM Codes for Tailor's Bunion
- M21.6X1: Other acquired deformities of right foot
- M21.6X2: Other acquired deformities of left foot
- M21.621: Bunionette of right foot
- M21.6X2: Bunionette of left foot

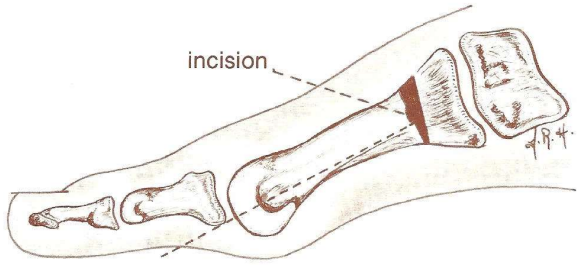
CPT Code 28110 (cont.)



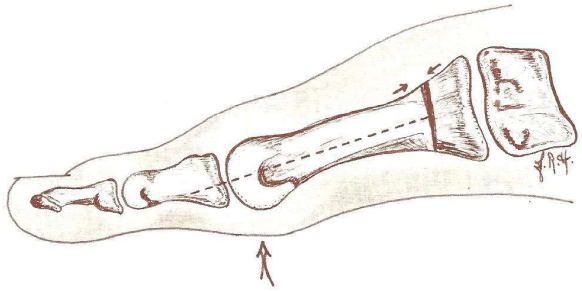
- If a 28308 (Osteotomy with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each) is performed with the ostectomy (CPT Code 28110), the ostectomy is considered incidental and is not paid separately
- These 2 CPT codes are bundled within the NCCI edits
- Since CPT code 28308 is the Column 1 code, CPT code 28110 is not reimbursable
- There is not an appropriate modifier to append to CPT code 28110 to allow payment

CPT Code 28306

Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal



Incision is made over area where osteotomy is to be performed. Extend osteotomy from initial fail-safe hole.

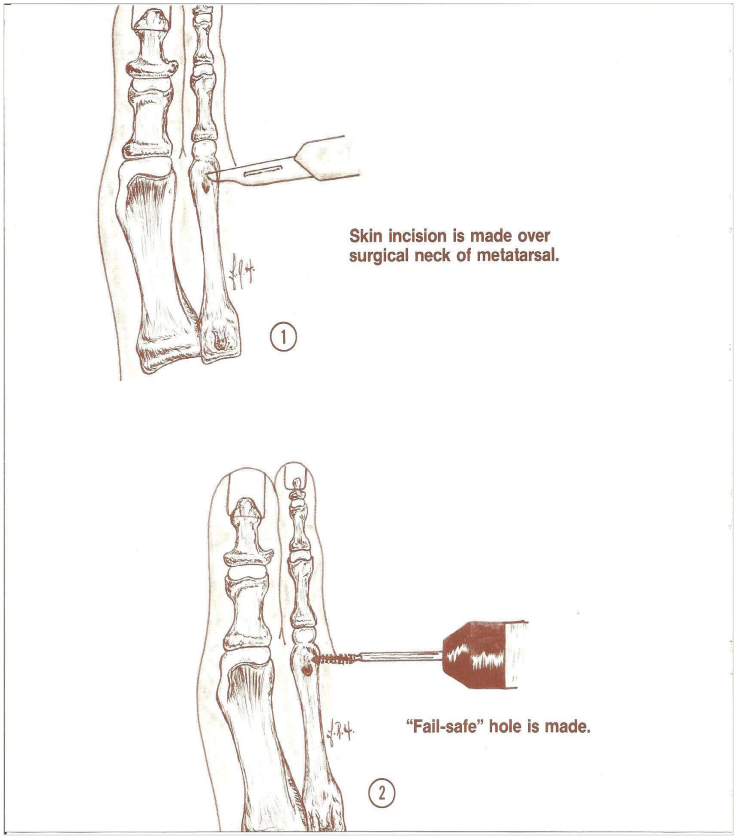


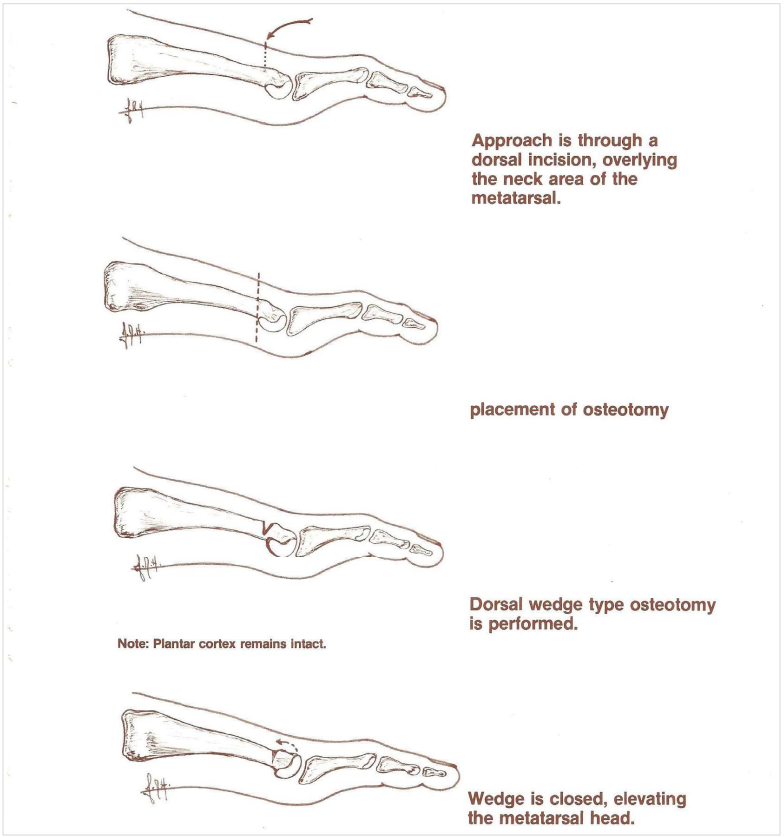
An alternative procedure is coded using CPT code 28740: Arthrodesis, midtarsal or tarsometatarsal, single joint

This would be performed at the 1st metatarsal medial cuneiform articulation

CPT Code 28308

Osteotomy with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each





CPT Code 28308 (cont.)

- A word or two about internal fixation
- The fee for any osteotomy includes the application AND the removal of the fixation. This applies to internal fixation.
- In general, the fee for ANY procedure that necessitates internal fixation includes the application AND the removal of the fixation.

- ICD-10-CM codes for CPT code 28308
- M21.6X1: Other acquired deformities of right foot
- M21.6X2: Other acquired deformities of left foot
- M24.374: Pathological dislocation of right foot, not elsewhere classified
- M24.375: Pathological dislocation of left foot, not elsewhere classified
- NOTE: M24.374 and M24.375 are appropriate for plantar plate tear/rupture

2022 Coding Change/Update
Implant vs. Foreign Body

Implant vs. Foreign Body

- **It is important to access the 2023 CPT Manual. Under Surgery Guidelines, you need to access the "Foreign Body/Implant Definition."**

Foreign Body/Implant Definition

- **“An object intentionally placed by a physician or other qualified health care professional for any purpose (eg. diagnostic or therapeutic) is considered an implant. An object that is unintentionally placed (eg. trauma or ingestion) is considered a foreign body. If an implant (or part thereof) has moved from its original position or is structurally broken and no longer serves its intended purpose or presents a hazard to the patient, it qualifies as a foreign body for coding purposes, unless CPT coding instructions direct otherwise or a specific CPT code exists to describe the removal of that broken/moved implant.”**

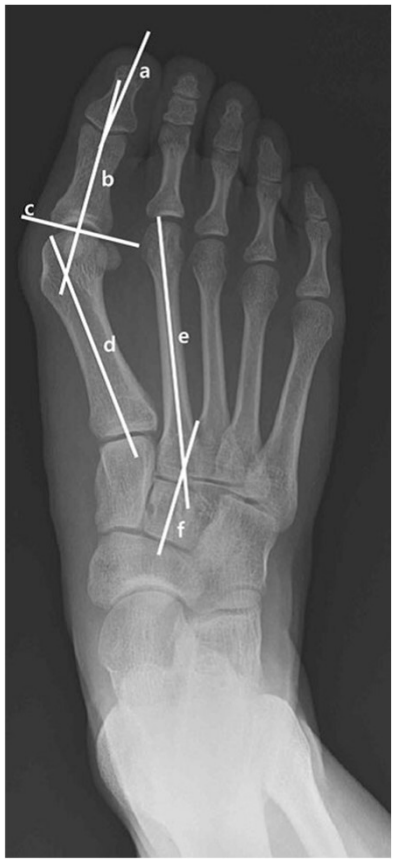
If Implant Needs to be Removed
(ie. Internal Fixation)

- **20680 Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)**

If Foreign Body is Removed

- **28190 Removal of foreign body, foot; subcutaneous**
- **28192 Removal of foreign body, foot; deep**
- **28193 Removal of foreign body, foot; complicated**

Additional Metatarsal Procedures of Note

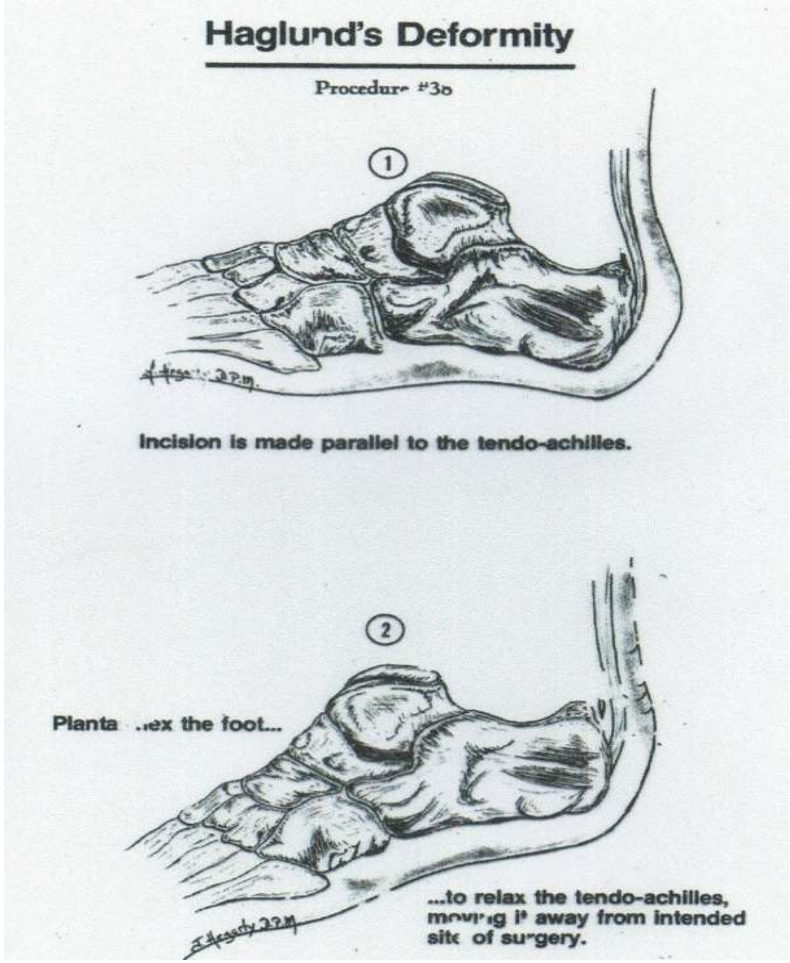


- 28111 Ostectomy, complete excision; first metatarsal head
- 28112 Ostectomy, complete excision; other metatarsal head (second, third or fourth)
- 28113 Ostectomy, complete excision; fifth metatarsal head
- 28114 Ostectomy, complete excision all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (e.g., Clayton type procedure)

CPT Code 28118

Ostectomy, calcaneus

- ICD-10-CM codes for CPT code 28118
- M89.371: Hypertrophy of bone, right ankle and foot
- M89.372: Hypertrophy of bone, left ankle and foot



CPT Code 28118 (cont.)

- What about the Achilles tendon?

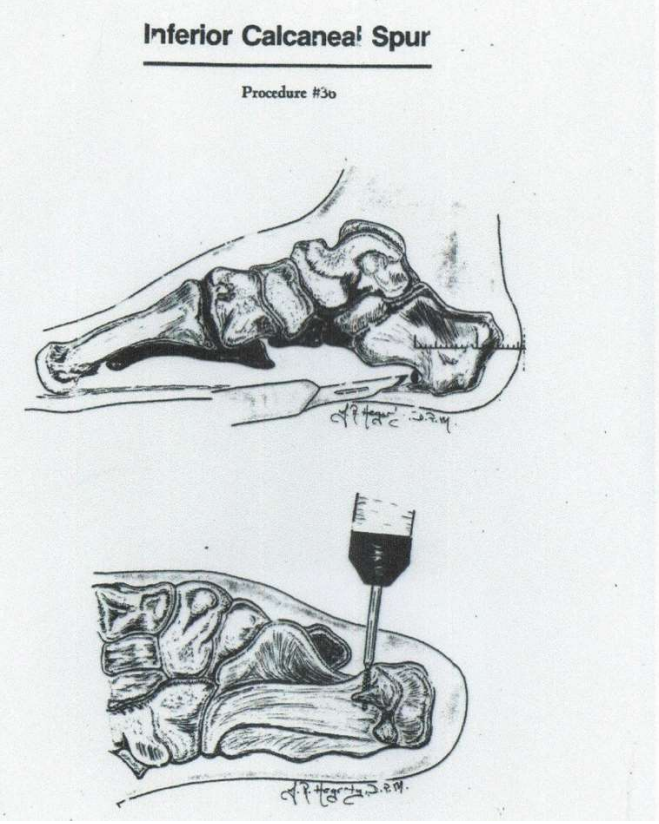
  Need to gain access to the underlying exostosis/bone spur. Achilles tendon needs to be detached from the posterior aspect of the calcaneus and then reattached.

  1. undamaged
  2. damaged

- CPT code 27654: Repair secondary, Achilles tendon, with or without graft

CPT Code 28119

Ostectomy, calcaneus; for spur, with or without plantar fascial release

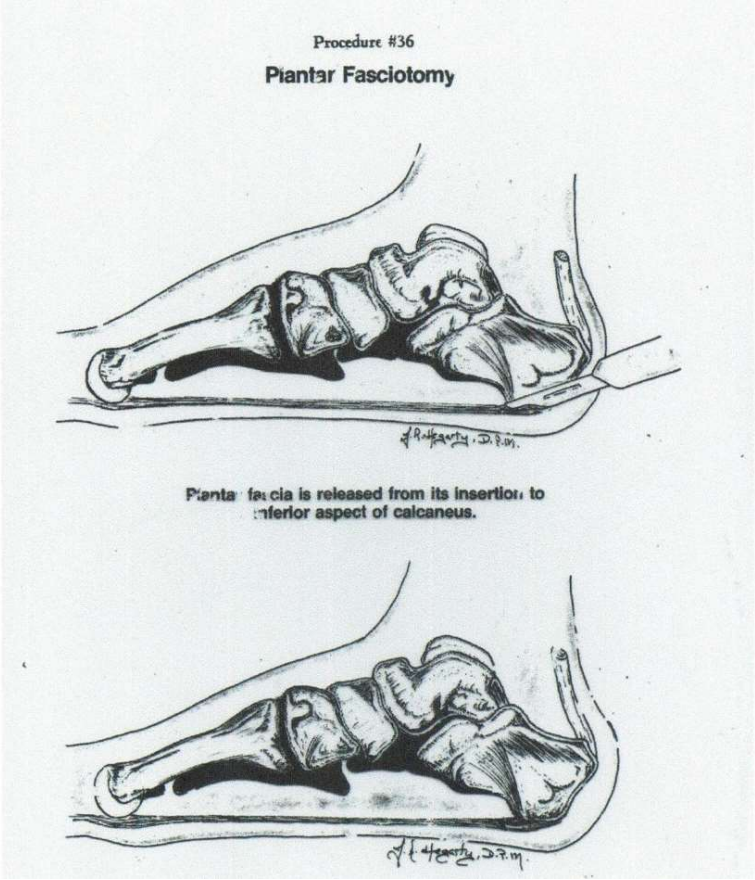


- ICD-10-CM codes for CPT code 28119
- M77.31: Calcaneal spur, right foot
- M77.32: Calcaneal spur, left foot

Even though a plantar fasciotomy is performed in order to gain access to the inferior calcaneal exostosis (aka heel spur), it is considered to be incidental to the removal of the spur and is not separately reimbursable (see the CCI edits: CPT codes 28119 and 28008 are bundled).

CPT Code 28008

Fasciotomy, foot and/or toe

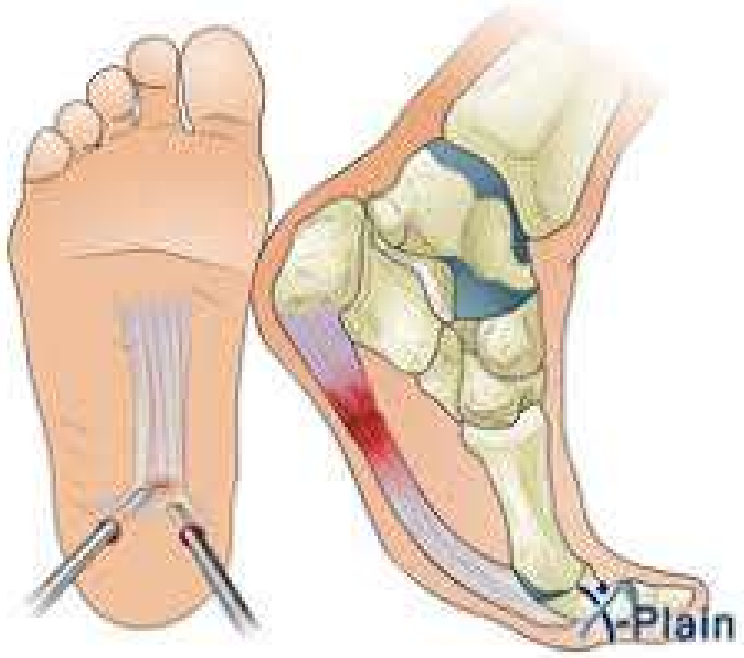


ICD-10-CM code for CPT code 28008

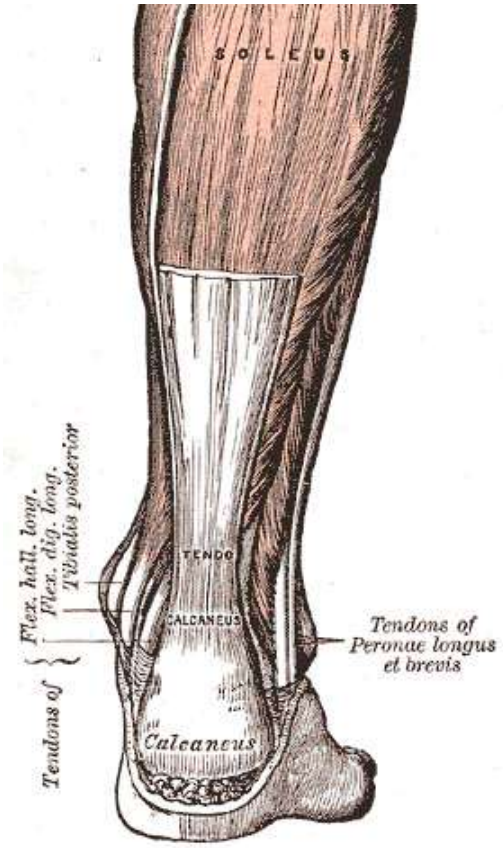
- M72.2: Plantar fasciitis

CPT Code 29893

Endoscopic plantar fasciotomy

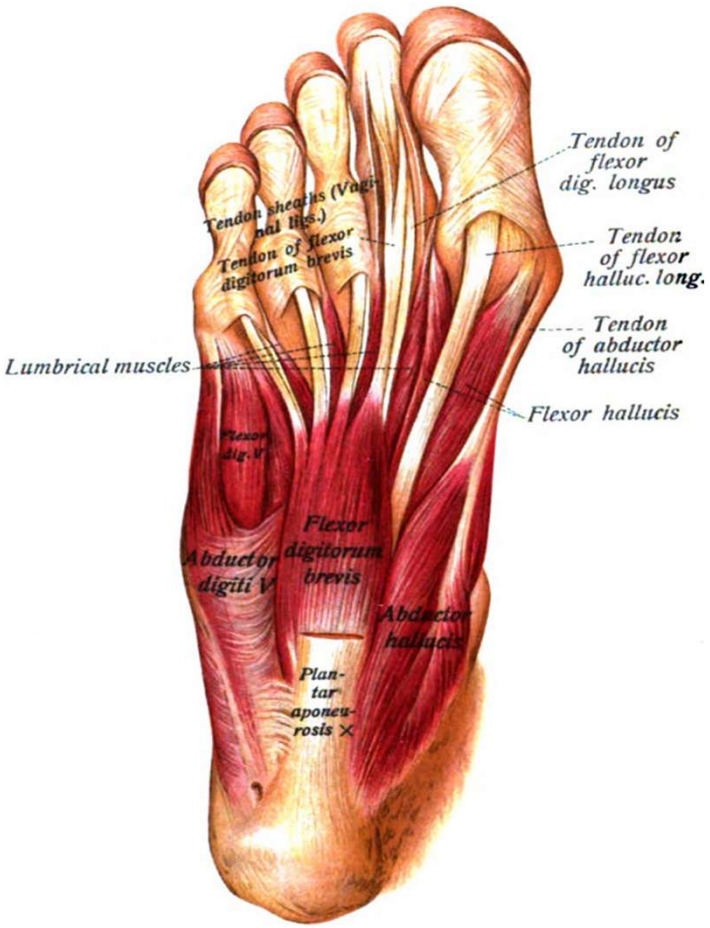


Repair of Tendons



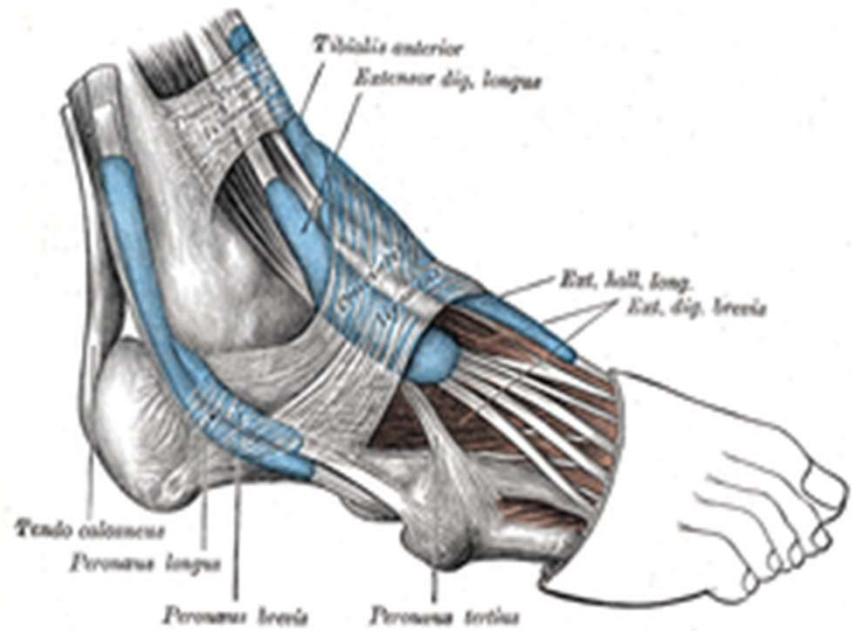
- 27650 Repair, primary, open or percutaneous, ruptured Achilles tendon
- 27652 Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
- 27654 Repair, secondary, Achilles tendon, with or without graft

Repair of Tendons



- 28200 Repair, tendon flexor, foot; primary or secondary, without free graft, each tendon
- 28202 Repair, tendon, flexor, foot; secondary with free graft, each tendon (includes obtaining graft)

Repair of Tendons



- 28208 Repair, tendon, extensor, foot; primary or secondary, each tendon
- 28210 Repair, tendon, extensor, foot; secondary with free graft, each tendon (includes obtaining graft)

AchillesTenotomy

- An ankle tenotomy is performed to treat a shortened or contracted tendon
- An Achilles tendon tenotomy is typically performed to treat an equinas deformity or to treat a clubfoot deformity

Achilles Tenotomy

- A small stab incision is made over the Achilles tendon at the planned site of the tenotomy. The tendon is then incised, usually using a Z-plasty, type of incision.

FIGURE 29-28 Technique of percutaneous Achilles tenotomy from medial to lateral; note proximity of peroneal artery, lesser saphenous vein, and sural nerve to lateral edge of tendon.

Achilles Tenotomy

- 27605 Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia
- 27606 Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia

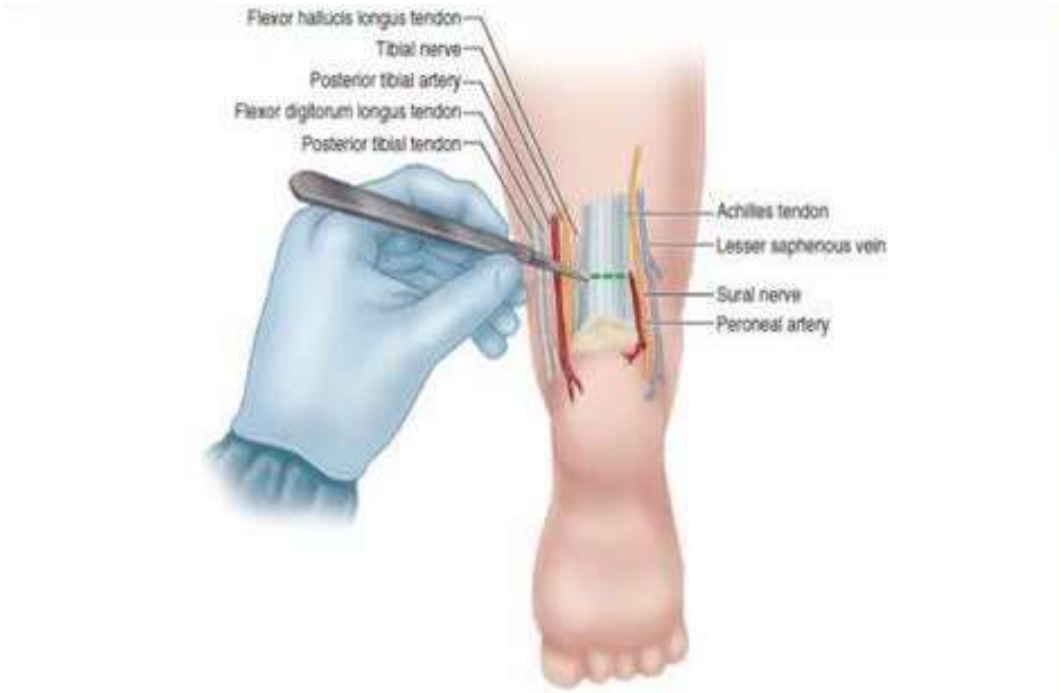


FIGURE 29-28 Technique of percutaneous Achilles tenotomy from medial to lateral; note proximity of peroneal artery, lesser saphenous vein, and sural nerve to lateral edge of tendon.

Subtalar Arthroreisis

At this point in time, Medicare as well as most commercial health insurance carriers do not recognize the performance of a subtalar arthroreisis as a reimbursable procedure or considers it to be experimental. Thus, there are three procedure codes to choose from when the procedure is

performed and reimbursement is sought.

S2117 Arthroreisis, subtalar

0335T Insertion of sinus tarsi implant
28899 Unlisted procedure, foot or toes

The claim should be submitted hard copy with an operative report to accurately support the code that is being billed.
If the insurance carrier is NOT Medicare, pre-authorize the procedure.

Postoperative Shoe

A postoperative shoe is NOT separately payable when it is dispensed in conjunction with a surgical procedure code. It is considered to be part of the procedure. In reality, the shoe is considered to be part of the dressing.

NO, you cannot have the patient sign an ABN and charge the patient for the shoe.

Hands-On
Cadaver Seminar
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Celebration, Florida

THANK YOU

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