NEW YORK STATE
MEDICAID PROGRAM

PODIATRY

FEE SCHEDULE

Table of Contents

GENERAL INFORMATION AND INSTRUCTIONS

1. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES**: The Federal Centers for Medicare and Medicaid Services (CMS) has mandated that all state Medicaid programs utilize the new Evaluation and Management coding as published in the American Medical Association's CPT.

   For the first time, a major section has been devoted entirely to E/M services. The new codes are more than a clarification of the old definitions; they represent a new way of classifying the work of practitioners. In particular, they involve far more clinical detail than the old visit codes. For this reason, it is important to treat the new codes as a new system and not make a one-for-one substitution of a new code number for a code number previously used to report a level of service defined as "brief", "limited", "intermediate", etc.

   The E/M section is divided into broad categories such as office visits and hospital visits. 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 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. This classification is important because the nature of practitioner work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office service. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See levels of E/M services following for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

2. **DEFINITIONS OF COMMONLY USED E/M TERMS**: Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting. (For complete procedure descriptions and fees, see page 4-14)

   NEW AND ESTABLISHED PATIENT: A new patient is one who has not received any professional services from the practitioner within the past three years. An established patient is one who has received professional services from the practitioner or another practitioner of the same specialty who belongs to the same group practice within the past three years.

In the instance where a practitioner is on call for or covering for another practitioner, the patient's encounter will be classified as it would have been by the practitioner who is not available. 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.

CHIEF COMPLAINT: A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

CONCURRENT CARE: is the provision of similar services, eg, hospital visits, to the same patient by more than one practitioner on the same day. When concurrent care is provided, no special reporting is required. Modifier -75 has been deleted.

COUNSELING: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and patient and family education.

FAMILY HISTORY: A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- diseases of family members which may be hereditary or place the patient at risk.

HISTORY OF PRESENT ILLNESS: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

NATURE OF PRESENTING PROBLEM: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal - A problem that may not require the presence of the practitioner, but service is provided under the practitioner's supervision.
- Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature and is not likely to **permanently** alter health status OR has a good prognosis with management/compliance.
- Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.
- High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

PAST HISTORY: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illness and injuries; prior operations;
- prior hospitalizations; current medications;
- allergies (eg, drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

SOCIAL HISTORY: An age appropriate review of past and current activities that include significant information about:

- martial status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

SYSTEM REVIEW (REVIEW OF SYSTEMS): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat

- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

TIME: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions. The inclusion of time as an explicit factor beginning in 1992 is done to assist practitioners in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for practitioners to provide accurate estimates of the time spent face-to-face with the patient. Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital or other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

A. **Face-to-face time (office and other outpatient visits):** For coding purposes, face-to-face time for these services is defined as only that time that the practitioner spends face-to-face with the patient and/or family. This includes the time in which the practitioner performs such tasks as obtaining a history, performing an examination, and counseling the patient.

   Practitioners also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This non face-to-face time for office services - also called pre and post-encounter time - is **not included** in the time component described in the E/M codes. However, the pre and post face-to-face work associated with an encounter was included in calculating the total work of typical services.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

B. **Unit/floor time (hospital inpatient care, nursing facility):** For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the practitioner is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the practitioner establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

3.A. **LEVELS OF E/M SERVICES:** Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are not interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, and similar medical services such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the

prevention or diagnosis and treatment of illness or injury and the promotion of optimal health.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history; examination; medical decision making; counseling; coordination of care; nature of presenting problem; and time.

The first three of these components (history, examination and medical decision making) are considered the **key** components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter. The final component, time, has already been discussed in detail.

3.B. **INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:**

i. IDENTIFY THE CATEGORY AND SUBCATEGORY OF SERVICE: Select from the categories and subcategories of codes available for reporting E/M services.

ii. REVIEW THE REPORTING INSTRUCTIONS FOR THE SELECTED CATEGORY OR SUBCATEGORY: 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 Care', special instructions will be presented preceding the levels of E/M services.

iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTORS IN THE SELECTED CATEGORY OR SUBCATEGORY: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time.

The first three of these components (ie, history, examination and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care (See vii c.).

The nature of the presenting problem and time are provided in some levels to assist the practitioner in determining the appropriate level of E/M service.

iv. DETERMINE THE EXTENT OF HISTORY OBTAINED: The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused -- chief complaint; brief history of present illness or problem.
- Expanded Problem Focused -- chief complaint; brief history of present illness; problem pertinent system review.
- Detailed -- chief complaint; extended history of present illness; problem pertinent system review extended to include review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patients problems.
- Comprehensive -- chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) indicated in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

v. DETERMINE THE EXTENT OF EXAMINATION PERFORMED: The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused -- a limited examination of the affected body area or organ system.
- Expanded Problem Focused -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive -- a general multi-system examination or a complete examination of a single organ system. **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

vi. DETERMINE THE COMPLEXITY OF MEDICAL DECISION MAKING: Medical decision making-refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and

- the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and, high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded:

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
minimal	minimal or none	minimal	straight-forward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

vii. SELECT THE APPROPRIATE LEVEL OF E/M SERVICES BASED ON THE FOLLOWING:

a. For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (ie, history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; initial hospital care; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

b. For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

c. In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling an/or coordination of care must be documented in the medical record.

4. **FOLLOW-UP DAYS:** Listed fees for all podiatry procedures include the service and the follow-up care for the period indicated in days in the column headed "Follow-Up Days." Necessary follow-up care beyond this listed period is to be added on a fee-for-service basis. When an additional procedure(s) is carried out within the listed period of follow-up care for a previous service, the follow-up periods will continue concurrently to their normal terminations.

5. **MULTIPLE SURGICAL PROCEDURES:**

a. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s) unless otherwise specified in this schedule. (For reporting bilateral surgical procedures, see modifier -50).

b. When an incidental procedure (eg, lysis of adhesions, removal of previous scar) is performed through the same incision, the fee will be that of the major procedure only.

6. **RADIOGRAPHIC STUDIES:**

a. MAXIMUM FEE: The dollar values identified as the maximum reimbursement level for X-rays are considered to include the cost of all materials necessary to complete the studies (eg, radiographic film, equipment, etc.).

b. MULTIPLE X-RAY EXAMS: When multiple X-ray examinations are performed during the same visit, the charge shall be based on the greater fee plus 60% of the lesser fee(s). When more than one part of the body is included in a single X-ray for which reimbursement is claimed, payment shall be only for a single X-ray. When bilateral X-ray examinations are performed during the same visit, reimbursement shall be limited to 160% of the procedure value (use modifier -WB). The above pricing procedures are applicable to X-rays taken of all parts of the body.

When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray,

it will be identified by adding modifier -76. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount).

7. **SURGERY REQUIRING HOSPITALIZATION:** Amputation procedures (codes 28805, 28810, 28820 and 28825) and the complicated surgical procedures identified by procedure codes 28290 and 28292 must be performed in a hospital setting.

8. **MATERIALS SUPPLIED BY PODIATRIST:** Supplies and materials provided by the podiatrist, eg, sterile trays/drugs, over and above those usually included with the office visit or other services rendered may be listed separately. Identify as 99070.

   Reimbursement for supplies and materials (including drugs, vaccines and immune globulins) furnished by practitioners to their patients is based on the acquisition cost to the practitioner. For all items furnished in this fashion it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost represented on the invoice. New York State Medicaid does not intend to pay more than the acquisition cost, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the practitioner is expected to limit his or her Medicaid claim amount to the actual invoice cost of the item provided.

9. **BY REPORT:** When the value of a procedure is to be determined "By Report" (BR), information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, is to be furnished. Appropriate documentation (eg, operative report, procedure description, and/or itemized invoices) should accompany all claims submitted.

   Itemized invoices must document acquisition cost, the line item cost from a manufacturer or wholesaler net of any rebates, discounts or other valuable considerations.

   When the value of a surgical procedure is indicated as "By Report" (BR), an Operative Report must be submitted with the MMIS claim form for a payment determination to be made. The Operative Report must include the following information:

   (a) Diagnosis (post-operative).
   (b) Size, location and number of lesion(s) or procedure(s) where appropriate.
   (c) Major surgical procedure and supplementary procedure(s).

(d) Whenever possible, list the nearest similar procedure by number according to these studies.
(e) Estimated follow-up period.
(f) Operative time.

Failure to submit an Operative Report when billing for a "By Report" surgical procedure will cause your claim to be denied by MMIS.

10. **UNLISTED PROCEDURES:** The value and appropriateness of services not specifically listed in this Fee Schedule will be manually reviewed by medical professional staff.

11. **ROUTINE FOOT CARE:** Routine foot care means: 1. the cutting or removal of corns, calluses, or warts and the trimming of nails (including mycotic nails); 2. other hygienic or preventive maintenance care considered to be self-care, such as cleaning and soaking of the feet; 3. the use of skin creams to maintain skin tone; 4. services performed in the absence of localized illness, injury, or symptoms involving the foot.

12. **FEES:** Listed fees are the maximum reimbursable Medicaid fees**.**

MMIS MODIFIERS

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral radiology procedures and surgical procedures requiring a separate incision that are performed at the same operative session, should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier -50 to the procedure number. (Reimbursement will not exceed 150% of the maximum State Medical Fee Schedule amount for surgery services or 160% of the maximum fee schedule amount for radiology services. One claim line is to be billed. Amount billed should reflect total amount due.)

-54 Surgical Care Only: When one practitioner performs a surgical procedure and another provides preoperative and/or postoperative management or postoperative management is to be provided in an outpatient department, surgical services may be identified by adding the modifier -54 to the usual procedure number. (Reimbursement will not exceed 80% of the maximum State Medical Fee Schedule amount.)

-76 Repeat X-ray Procedure: When a repeat X-ray examination of the same part and for the same illness is required for reasons other than technical or professional error in the original X-ray, it will be identified by adding modifier -76.

(Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount).

-77 Repeat Procedure By Another Physician: The practitioner may need to indicate that a basic procedure performed by another practitioner had to be repeated. This situation may be reported by adding modifier -77 to the repeated service. (Reimbursement will not exceed 100% of the maximum State Medical Fee Schedule amount.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier -99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

LABORATORY SERVICES PERFORMED IN A PODIATRIST'S OFFICE

Certain laboratory procedures specified below are eligible for direct podiatry reimbursement when performed in the office of the podiatrist in the course of treatment of his own patients.

Procedures other than those specified must be performed by a laboratory holding a valid clinical laboratory permit in the commensurate laboratory specialty issued by the New York State Department of Health or, where appropriate, the New York City Department of Health.

Procedure code 81000 and 81002 includes reimbursement for measurement of all qualitative and semi-quantitative determinations by reagent strip methodology.

Procedure code 85021 or 85022, complete blood count (CBC), may not be billed with its component codes 85007, 85013,85018,85041 or 85048.

81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	$ 4.00
81002	non-automated, without microscopy	$2.00
81015	Urinalysis; microscopic only	$2.00
85007	Blood count; blood smear, microscopic examination, with manual differential WBC count (includes RBC morphology and platelet estimation)	$1.43
85013	spun microhematrocrit	$2.00
85018	hemoglobin (Hgb)	$2.00
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	$3.17

	Blood count;	
85041	red blood cell (RBC) automated	$3.17
85048	leukocyte (WBC), automated	$3.17
85651	Sedimentation rate, erythrocyte; non-automated	$2.00
85652	automated	$2.00

NOTE: Medicare reimburses for the above services at 100 percent. No Medicare co-insurance payments may be billed for the above listed procedure codes.

MEDICAL SERVICES

EVALUATION AND MANAGEMENT CODES

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problems(s) and the patient's and/or family's needs.

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the practitioners office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs. When claiming for Evaluation and Management procedure codes 99201-99205 and 99211-99215 Office or Other Outpatient Services, report the place of service code that represents the location where the service was rendered in claim form field 24B Place of Service. The maximum reimbursable amount for these codes is dependent on the Place of Service reported.

For Evaluation and Management services rendered in the practitioners private office, report place of service "1". The Maximum Fee-NYS for Office Evaluation and Management services noted below. For services rendered in a Hospital Outpatient setting report place of service "7". For the Maximum Fee-NYS for codes 99201-99205 and 99211-99215 in a Hospital Outpatient setting see the dollar amount noted in parenthesis in the Maximum Fee-NYS column.

For services provided by practitioners in the Emergency Department, see 99281-99285. For services provided to hospital inpatients, see Hospital Services 99221-99239.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or comprehensive nursing facility assessments.

NEW PATIENT

99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward decision making. Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.	$5.00 (8.00)
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 20 minutes face-to-face with the patient and/or family.	$5.00 (8.00)
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Practitioners typically spend 30 minutes face-to-face with the patient and/or family.	$6.50 (8.00)
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 45 minutes face-to-face with the patient and/or family.	$6.50 (8.00)

99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$6.50 (8.00)

ESTABLISHED PATIENT

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a podiatrist. Usually, the presenting problem(s) are minimal. Typically 5 minutes are spent performing or supervising these services.	$5.00 (5.00)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history, a problem focused examination, and/or straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Practitioners typically spend 10 minutes face-to-face with the patient and/or family.	$5.00 (5.00)
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem focused examination, and/or medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.	$6.50 (5.00)

99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and/or medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.	$6.50 (5.00)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination and/or medical decision making of of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.	$6.50 (5.00)

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to inpatients.

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

The following codes are used to report the first hospital encounter with the patient by the admitting practitioner. For initial inpatient encounters by practitioners other than the admitting practitioner see subsequent hospital care codes (99231-99233) as appropriate.

99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making that is straightforward or of low complexity Usually, the problem(s) requiring admission are of low severity. Practitioners typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.	$8.00

99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity. Practitioners typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.	$8.00
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity. Practitioners typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.	$ 8.00

SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (ie, changes in history, physical condition and response to management) since the last assessment by the practitioner.

99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history, a problem focused examination, decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	$5.00

99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.	$5.00
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history, a detailed examination, and/or medical decision making of high complexity. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	$5.00

HOSPITAL DISCHARGE SERVICES

The hospital discharge day management codes are to be used to report the total duration of time spent by a practitioner for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the practitioner on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

99238	Hospital discharge day management; 30 minutes or less	$5.00
99239	more than 30 minutes	$5.00

(These codes are to be utilized by the practitioner to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient, and discharged on the same date, use only the codes for Initial Hospital Inpatient Services, 99221-99223. To report concurrent care services provided by a practitioner(s) other than the attending practitioner, use subsequent hospital care codes (99231-99233) on the day of discharge.)

EMERGENCY DEPARTMENT SERVICES - NEW OR ESTABLISHED PATIENT

The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history, a problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.	$8.00
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity.	$8.00
99283	Emergency department visit for the evaluation and management of a patient which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low to moderate complexity. Usually, the presenting problem(s) are of moderate severity.	$8.00
99284	Emergency department visit for the evaluation and management of a patient which requires these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the practitioner but do not pose an immediate significant threat to life or physiologic function.	$8.00

99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: a comprehensive history, a comprehensive examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$8.00

NURSING FACILITY SERVICES

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs).

COMPREHENSIVE NURSING FACILITY ASSESSMENTS - NEW OR ESTABLISHED PATIENT

More than one comprehensive assessment may be necessary during an inpatient confinement.

99301	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Practitioners typically spend 30 minutes at the bedside and on the patient's facility floor or unit.	$8.00
99302	Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history, a comprehensive examination, and medical decision making of moderate to high complexity. Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required. Practitioners typically spend 40 minutes at the bedside and on the patient's facility floor or unit.	$8.00

99303	Evaluation and management of a new or established patient involving nursing facility assessment at the time of initial admission to the facility, which requires these three key components: a comprehensive history, a comprehensive examination, and medical decision making of moderate to high complexity. The creation of a medical plan of care is required. Practitioners typically spend 50 minutes at the bedside and on the patient's facility floor or unit.	$8.00

SUBSEQUENT NURSING FACILITY CARE

The following codes are used to report the services provided to residents of nursing facilities who do not require a comprehensive assessment, and/or who have not had a major, permanent change of status.

All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

99311	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these key components: a problem focused interval history, a problem focused examination and/or medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Practitioners typically spend 15 minutes at the bedside and on the patient's facility floor or unit.	$7.00
99312	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Practitioners typically spend 25 minutes at the bedside and on the patient's facility floor or unit.	$7.00

99313	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these key components: a detailed interval history, a detailed examination, and/or medical decision making of moderate to high complexity. Usually, the patient has developed a significant complication or a significant new problem. Practitioners typically spend 35 minutes at the bedside and on the patient's facility floor or unit.	$7.00

DOMICILIARY, REST HOME (eg, BOARDING HOME), OR CUSTODIAL CARE SERVICES

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include medical component. Typical times have not yet been established for this category of services.

NEW PATIENT

99321	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward or of low complexity Usually, the presenting problem(s) are of low severity.	$7.00
99322	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history, an expanded problem focused examination, and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.	$8.00
99323	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high complexity.	$8.00

ESTABLISHED PATIENT

99331	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem problem focused interval history, a problem focused examination, and/or medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving.	$7.00
99332	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history, an expanded problem focused examination, and/or medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication.	$8.00
99333	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history, a detailed examination and/or medical decision making of high complexity. Usually, the patient is unstable or has developed a significant complication or a significant new problem.	$8.00

HOME SERVICES

The following codes are used to report evaluation and management services provided in a private residence.

Typical times have not yet been established for this category of services.

NEW PATIENT

99341	Home visit for the evaluation and management of a new patient which requires these three key components: a problem focused history, a problem focused examination, and medical decision making that is straightforward or of low complexity. Usually, the presenting problem(s) are of low severity.	$7.00

99342	Home visit for the evaluation and management of a new patient which requires these three key components: an expanded problem focused history, an expanded problem focused examination and medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.	$8.00
99343	Home visit for the evaluation and management of a new patient which requires these three key components: a detailed history, a detailed examination, and medical decision making of high complexity. Usually, the presenting problem(s) are of high severity.	$8.00
99344	Home visit for the evaluation and management of a new patient which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of high severity. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$8.00
99345	Home visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of high complexity. Usually the patient is unstable or has developed a significant new problem requiring immediate practitioner attention. Practitioners typically spend 75 minutes face-to-face with the patient and/or family.	$8.00

ESTABLISHED PATIENT

99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination, and straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Practitioners typically spend 15 minutes face-to-face with the patient and/or family.	$7.00

99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination and medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Practitioners typically spend 25 minutes face-to-face with the patient and/or family.	$8.00
99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Practitioners typically spend 40 minutes face-to-face with the patient and/or family.	$8.00
99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate practitioner attention. Practitioners typically spend 60 minutes face-to-face with the patient and/or family.	$8.00

SURGICAL SERVICES

INTEGUMENTARY SYSTEM

Fees for services listed in this section (codes 10060 -17340) should be reduced by 50 percent when performed subsequent to partial or complete excision of nail and nail matrix (code 11750) on the same toe, within a 30-day interval.

			Follow Up Days
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	$8.00	
10061	complicated or multiple	$24.00	
10120	Incision and removal of foreign body, subcutaneous tissues; simple	$8.00	
10121	complicated	$16.00	
10140	Incision and drainage of hematoma, seroma or fluid collection	$8.00	
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	$4.00	
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion	$12.00	15
11101	each separate/additional lesion	$12.00	30

The excised lesion(s) should be measured and recorded in centimeters, whether curved, angular or stellate. When multiple lesions are repaired, add together the lengths and report as a single item.

11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), feet; lesion diameter 0.5 cm or less	$16.00	30
11421	excised diameter 0.6 to 1.0 cm	$20.00	30
11422	excised diameter 1.1 to 2.0 cm	$24.00	30
11423	excised diameter 2.1 to 3.0 cm	$36.00	30

To expedite Medicaid reimbursement for debridement services (ie, procedure codes 11720 & 11721), the primary and secondary diagnoses should be specified in the appropriate claim form fields. Additional explanatory information indicative of pathological conditions necessitating frequent repetition of these services should also be provided to facilitate payment.

11720	Debridement of nail(s), by any method(s); one to five	$8.00	
11721	six or more	$12.00	
11730	Avulsion of nail plate, partial or complete, simple; single	$8.00	
11732	each additional nail plate	$2.00	
11740	Evacuation of subungual hematoma	$4.00	
11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal	$40.00	30

			Follow Up Days
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	$12.00	

The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular or stellate. When multiple wounds are repaired, add together the lengths and report as a single item.

12001	Simple repair of superficial wounds; of 2.5 cm or less	$8.00	
12002	2.6 cm to 7.5 cm	$10.00	
12004	7.6 cm to 12.5 cm	$12.00	
12005	12.6 cm to 20.0 cm	$14.00	
12020	Treatment of superficial wound dehiscence; simple closure	BR	
16000	Initial treatment, first degree burn, when no more than local treatment is required	$6.00	
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion.	$12.00	
17003	second through 14 lesions, each	$4.00	
17004	15 or more lesions (do not report in conjunction with 17000 or 17003)	BR	
17110	Destruction, (eg, laser surgery, electrosurgery, cryosurgery, surgical curettement) of flat warts or molluscum contagiosum, or milia, up to 14 lesions (Retreatment same as office visit)	$8.00	
17111	15 or more lesions	$11.00	
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)	$8.00	
17340	Cryotherapy (C02 slush, liquid N2)	$6.00	

MUSCULOSKELETAL SYSTEM

20600	Arthrocentesis, aspiration and/or injection; small joint, or bursa (eg, toes)	$8.00	
20612	Aspiration and/or injection or ganglion cyst(s)	$12.00	
28001	Incision and drainage, bursa, foot	$12.00	
28008	Fasciotomy, foot and/or toe	$40.00	60
28010	Tenotomy, subcutaneous, toe; single	$20.00	
28011	multiple	$30.00	

			Follow Up Days
Procedure codes 28020-28024 and 28315 are to be billed only when the arthrotomy is done in conjunction with open reduction of the joint, or for removal of a loose body (eg, osteochondritis, foreign body, etc.) when radiographic confirmation had been obtained postoperatively.			
28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint	$120.00	90
28022	metatarsophalangeal joint	$40.00	60
28024	interphalangeal joint	$60.00	60
28090	Excision of lesion, tendon, tendon sheath or capsule (including synovectomy)(cyst or ganglion); foot	$60.00	30
28092	toes	$40.00	30
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus	$100.00	90
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus	$100.00	90
28280	Syndactylism, e.g., webbing or Kelikian type procedure	$156.30	60
28285	Correction hammertoe; (eg, interphalangeal fusion, partial or total, phalangectomy)	$80.00	120
For Codes 28290-28292, see General Information and Instructions #7			
28290	Correction hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (Silver type procedure)	$80.00	60
28292	Keller, McBride or Mayo type procedure	$120.00	120
28302	Osteotomy; talus	$120.00	120
28304	Osteotomy, tarsal bones, other than calcaneus or talus	$120.00	120
28306	Osteotomy, with or without lengthening, shortening or angular correction, first metatarsal	$120.00	120
28308	other than first metatarsal	$120.00	120
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)	$120.00	120
28312	other phalanges, any toe	$120.00	120

			Follow Up Days
28315	Sesamoidectomy, first toe (separate procedure)	$60.00	60

FRACTURE AND/OR DISLOCATION

28450	Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each	$30.00	45
28455	with manipulation, each	$40.00	90
28470	Closed treatment of metatarsal fracture; without manipulation, each	$30.00	45
28475	with manipulation, each	$40.00	90
28490	Closed treatment of fracture great toe, phalanx or phalanges; without manipulation	$12.00	30
28495	with manipulation	$20.00	60
28510	Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each	$12.00	30
28515	with manipulation, each	$20.00	60
28630	Closed treatment of metatarsophalangeal joint dislocation; without anesthesia	$28.00	45
28635	requiring anesthesia	$28.00	45
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	$8.00	
28665	requiring anesthesia	$8.00	30

AMPUTATION

For codes 28805-28825, see General Information and Instructions #7

28805	Amputation, foot; transmetatarsal	$140.00	90
28810	Amputation, metatarsal, with toe, single	$100.00	90
28820	Amputation, toe; metatarsophalangeal joint	$40.00	45
28825	interphalangeal joint	$40.00	45
28899	UNLISTED PROCEDURE, foot or toes	BR	

APPLICATION OF CASTS AND STRAPPING

Fees for codes 29405 and 29425 exclude cost of materials.

29405	Application of short leg cast (below knee to toes);	$12.00	2
29425	walking or ambulatory type	$14.00	2
29580	Strapping; Unna Boot	$8.00	2

PERIPHERAL NERVES

			Follow Up Days
64450	Injection, anesthetic agent; other peripheral nerve or branch	$12.00	7
64776	Excision of neuroma; digital nerve, one or both, same digit	$40.00	60
64778	digital nerve, each additional digit	$6.00	
64782	foot, except digital nerve	$60.00	60
64783	foot, each additional nerve, except same digit	$6.00	

RADIOLOGY

73600	Radiologic examination, ankle; two views	$10.00
73610	complete, minimum of three views	$12.50
73620	Radiologic examination, foot; two views	$10.00
73630	complete, minimum of three views	$12.50
73660	Radiologic examination; toe or toes, minimum of two views	$7.50

MISCELLANEOUS

99070	Supplies and materials provided by the podiatrist over and above those usually included with the office visit or other services rendered	BR
90799	Unlisted therapeutic injection (material used for each injection may be charged at acquisition cost rounded to nearest one dollar amount)	BR