PODIATRY
Procedure Codes

eMedNY New York State Medicaid Provider Procedure Code Manual
New York State Medicaid
Office of Health Insurance
Department of Health

CONTACTS and LINKS:

eMedNY URL
https://www.emedny.org/

ePACES Reference Guide

eMedNY Contact Information
(800) 343-9000
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2 GENERAL INFORMATION AND INSTRUCTIONS

A. **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.

B. **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 Evaluation and Management guidelines in the CPT book should be referenced when selecting the level of E/M codes.

C. **FOLLOW-UP (F/U) 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 "FU Days" in the Fee Schedule. 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.

D. **MULTIPLE SURGICAL PROCEDURES**:
   1. 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).
2. When an incidental procedure (e.g., lysis of adhesions, removal of previous scar) is performed through the same incision, the fee will be that of the major procedure only.

E. RADIOGRAPHIC STUDIES:
1. 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 (e.g., radiographic film, equipment, etc.).
2. 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 -50). 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).

F. SURGERY REQUIRING A HOSPITAL SETTING: Amputation procedures (codes 28805, 28810, 28820 and 28825) and the complicated surgical procedure identified by code 28292 must be performed in a hospital setting.

G. MATERIALS SUPPLIED BY PODIATRIST: Supplies and materials provided by the podiatrist, e.g., 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.

H. BY REPORT: When the value of a procedure is to be determined "By Report" (BR), as indicated in the Fee Schedule, 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 (e.g., 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 claim form for a payment determination to be made. The Operative Report must include the following information:

1. Diagnosis (post-operative).
2. Size, location and number of lesion(s) or procedure(s) where appropriate.
3. Major surgical procedure and supplementary procedure(s).
4. Whenever possible, list the nearest similar procedure by number according to these studies.
5. Estimated follow-up period.
6. Operative time.

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

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

J. 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.

K. FEES: The fees are listed in the Podiatry Fee Schedule, available at: [http://www.emedny.org/ProviderManuals/Podiatry/](http://www.emedny.org/ProviderManuals/Podiatry/)

Listed fees are the maximum reimbursable Medicaid fees.

### 3 MMIS MODIFIERS

Note: NCCI associated modifiers are recognized for NCCI code pairs/related edits. For additional information please refer to the CMS website: [http://www.cms.hhs.gov/NationalCorrectCodInitEd/](http://www.cms.hhs.gov/NationalCorrectCodInitEd/)

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. To indicate a bilateral procedure was done add 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, 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.)

4 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 85025 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

81002 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, without microscopy

81015 Urinalysis; microscopic only

85007 Blood count; blood smear, microscopic examination, with manual differential WBC count (includes RBC morphology and platelet estimation)
85013  spun microhematocrit
85018  hemoglobin (Hgb)
85025  complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count Blood count;
85041  red blood cell (RBC) automated
85048  leukocyte (WBC), automated
85651 Sedimentation rate, erythrocyte; non-automated
85652 automated

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

5 MEDICAL SERVICES

5.1 EVALUATION AND MANAGEMENT CODES
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

5.2 OFFICE OR OTHER OUTPATIENT SERVICES

5.2.1 NEW PATIENT
99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

5.2.2 ESTABLISHED PATIENT
99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.
99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19
minutes of total time is spent on the date of the encounter.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

5.3 HOSPITAL INPATIENT OR OBSERVATION CARE

5.3.1 INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

99221 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99222 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

99223 Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high-level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

5.3.2 SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE

99231 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or executed.

99232 Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or executed.

99233 Subsequent hospital inpatient or observation care, per day, for the evaluation and
management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or executed.

5.3.3 HOSPITAL INPATIENT OR OBSERVATION DISCHARGE SERVICES
99238 Hospital discharge day management; 30 minutes or less
99239 more than 30 minutes

5.4 EMERGENCY DEPARTMENT SERVICES
5.4.1 NEW OR ESTABLISHED PATIENT
99281 Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99284 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285 Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

5.5 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).

5.5.1 INITIAL NURSING FACILITY CARE
5.5.1.1 NEW OR ESTABLISHED PATIENT
99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which
requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

5.5.2 SUBSEQUENT NURSING FACILITY CARE
99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low-level of medical decision making.
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

5.6 HOME OR RESIDENCE SERVICES
5.6.1 NEW PATIENT
99341 Home visit for the evaluation and management of a new patient which requires medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342 Home visit for the evaluation and management of a new patient which requires medically appropriate history and/or examination and low level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344 Home visit for the evaluation and management of a new patient which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
5.6.2 ESTABLISHED PATIENT
99347 Home residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and straightforward medical decision making.
When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99348 Home residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and low level of medical decision making.
When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99349 Home residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and moderate level of medical decision making.
When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

99350 Home residence visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and high level of medical decision making.
When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

5.6.3 PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE VISIT OR OTHER OUTPATIENT SERVICE
99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)

6 SURGICAL SERVICES
6.1 INTEGUMENTARY SYSTEM
Fees, as listed in the Fee Schedule, for services listed in this section (codes 10060-17250) 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.

10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or
subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10061  complicated or multiple
10120  Incision and removal of foreign body, subcutaneous tissues; simple
10121  complicated
10140  Incision and drainage of hematoma, seroma or fluid collection
10160  Puncture aspiration of abscess, hematoma, bulla, or cyst
11102  Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
11103  each separate/additional lesion (List separately in addition to code for primary
procedure)
11104  Punch biopsy of skin (including simple closure, when performed); single lesion
11105  each separate/additional lesion (List separately in addition to code for primary
procedure)
11106  Incisional biopsy of skin (eg, wedge) (including simple skin closure, when performed); single lesion
11107  each separate/additional lesion (List separately in addition to code for primary
procedure)
11420  Excision, benign lesion including margins, except skin tag (unless listed elsewhere), feet;
lesion diameter 0.5 cm or less
11421  excised diameter 0.6 to 1.0 cm
11422  excised diameter 1.1 to 2.0 cm
11423  excised diameter 2.1 to 3.0 cm
(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
11721  six or more
11730  Avulsion of nail plate, partial or complete, simple; single
11732  each additional nail plate
11740  Evacuation of subungual hematoma
11750  Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for
permanent removal
11755  Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)
(separate procedure)
(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
12002  2.6 cm to 7.5 cm
12004  7.6 cm to 12.5 cm
12005  12.6 cm to 20.0 cm
12020  Treatment of superficial wound dehiscence; simple closure
16000  Initial treatment, first degree burn, when no more than local treatment is required
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>17000</td>
<td>Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemo-</td>
</tr>
<tr>
<td></td>
<td>surgery, surgical curettage), premalignant lesions (eg, actinic keratoses;</td>
</tr>
<tr>
<td></td>
<td>first lesion</td>
</tr>
<tr>
<td>17003</td>
<td>second through 14 lesions, each</td>
</tr>
<tr>
<td>17004</td>
<td>15 or more lesions</td>
</tr>
<tr>
<td>17110</td>
<td>Destruction, (eg, laser surgery, electrosurgery, cryosurgery, chemo-</td>
</tr>
<tr>
<td></td>
<td>surgery, surgical curettage), of benign lesions other than skin tags or</td>
</tr>
<tr>
<td></td>
<td>cutaneous vascular lesions; up to 14 lesions</td>
</tr>
<tr>
<td>17111</td>
<td>15 or more lesions</td>
</tr>
<tr>
<td>17250</td>
<td>Chemical cauterization of granulation tissue (ie, proud flesh)</td>
</tr>
</tbody>
</table>

### 6.2 MUSCULOSKELETAL SYSTEM

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>20600</td>
<td>Arthrocentesis, aspiration and/or injection; small joint or bursa (eg,</td>
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<tr>
<td></td>
<td>toes) without ultrasound guidance</td>
</tr>
<tr>
<td>20612</td>
<td>Aspiration and/or injection or ganglion cyst(s)</td>
</tr>
<tr>
<td>28000</td>
<td>Incision and drainage, bursa, foot</td>
</tr>
<tr>
<td>28008</td>
<td>Fasciotomy, foot and/or toe</td>
</tr>
<tr>
<td>28010</td>
<td>Tenotomy, subcutaneous, toe; single</td>
</tr>
<tr>
<td>28011</td>
<td>multiple</td>
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<tr>
<td></td>
<td>(Procedure codes 28020-28024 and 28315 are to be billed only when the</td>
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<tr>
<td></td>
<td>arthrotomy is done in conjunction with open reduction of the joint, or for</td>
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<td></td>
<td>removal of a loose body (eg, osteochondritis, foreign body, etc.) when</td>
</tr>
<tr>
<td></td>
<td>radiographic confirmation had been obtained postoperatively).</td>
</tr>
<tr>
<td>28020</td>
<td>Arthrotomy, with exploration, drainage or removal of loose or foreign</td>
</tr>
<tr>
<td></td>
<td>body; intertarsal or tarsometatarsal joint</td>
</tr>
<tr>
<td>28022</td>
<td>metatarsophalangeal joint</td>
</tr>
<tr>
<td>28024</td>
<td>interphalangeal joint</td>
</tr>
<tr>
<td>28090</td>
<td>Excision of lesion, tendon, tendon sheath or capsule (including synovectomy</td>
</tr>
<tr>
<td></td>
<td>(cyst or ganglion); foot</td>
</tr>
<tr>
<td>28092</td>
<td>toes</td>
</tr>
<tr>
<td>28100</td>
<td>Excision or curettage of bone cyst or benign tumor, talus or calcaneus</td>
</tr>
<tr>
<td>28104</td>
<td>Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal,</td>
</tr>
<tr>
<td></td>
<td>except talus or calcaneus</td>
</tr>
<tr>
<td>28280</td>
<td>Syndactylism, e.g., webbing or Kelikian type procedure</td>
</tr>
<tr>
<td>28285</td>
<td>Correction hammertoe; (eg, interphalangeal fusion, partial or total,</td>
</tr>
<tr>
<td></td>
<td>phalanectomy)</td>
</tr>
<tr>
<td>28292</td>
<td>Correction, hallux valgus (bunionectomy), with sesamoidectomy, when</td>
</tr>
<tr>
<td></td>
<td>performed; with resection of proximal phalanx base, when performed, any</td>
</tr>
<tr>
<td></td>
<td>method</td>
</tr>
<tr>
<td>28302</td>
<td>Osteotomy; talus</td>
</tr>
<tr>
<td>28304</td>
<td>Osteotomy, tarsal bones, other than calcaneus or talus</td>
</tr>
<tr>
<td>28306</td>
<td>Osteotomy, with or without lengthening, shortening or angular correction,</td>
</tr>
<tr>
<td></td>
<td>first metatarsal</td>
</tr>
<tr>
<td>28308</td>
<td>other than first metatarsal</td>
</tr>
<tr>
<td>28310</td>
<td>Osteotomy, shortening, angular or rotational correction; proximal phalanx,</td>
</tr>
<tr>
<td></td>
<td>first toe (separate procedure)</td>
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</tbody>
</table>
28312  other phalanges, any toe
28315  Sesamoidectomy, first toe (separate procedure)

### 6.2.1 FRACTURE AND/OR DISLOCATION

- **28450**  Treatment of tarsal bone fracture (except talus and calcaneus); without manipulation, each
- **28455**  with manipulation, each
- **28470**  Closed treatment of metatarsal fracture; without manipulation, each
- **28475**  with manipulation, each
- **28490**  Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
- **28495**  with manipulation
- **28510**  Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each
- **28515**  with manipulation, each
- **28630**  Closed treatment of metatarsophalangeal joint dislocation; without anesthesia
- **28635**  requiring anesthesia
- **28660**  Closed treatment of interphalangeal joint dislocation; without anesthesia
- **28665**  requiring anesthesia

### 6.2.2 AMPUTATION

(For codes 28805-28825, see General Information and Instructions)

- **28805**  Amputation, foot; transmetatarsal
- **28810**  Amputation, metatarsal, with toe, single
- **28820**  Amputation, toe; metatarsophalangeal joint
- **28825**  interphalangeal joint
- **28899**  UNLISTED PROCEDURE, foot or toes

### 6.3 APPLICATION OF CASTS AND STRAPPING

#### 6.3.1 LOWER EXTREMITY

(Fees for codes 29405 and 29425 exclude cost of materials.)

- **29405**  Application of short leg cast (below knee to toes);
- **29425**  walking or ambulatory type
- **29580**  Strapping; Unna Boot

### 7 NERVOUS SYSTEM SERVICES

#### 7.1 PERIPHERAL NERVES

- **64450**  Injection, anesthetic agent; other peripheral nerve or branch
- **64455**  plantar common digital nerve(s) (eg, Morton’s neuroma)
- **64632**  Destruction by neurolytic agent; plantar common digital nerve
- **64776**  Excision of neuroma; digital nerve, one or both, same digit
- **64778**  digital nerve, each additional digit
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64782</td>
<td>foot, except digital nerve</td>
</tr>
<tr>
<td>64783</td>
<td>foot, each additional nerve, except same digit</td>
</tr>
</tbody>
</table>

### 8 RADIOLOGY SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73600</td>
<td>Radiologic examination, ankle; two views</td>
</tr>
<tr>
<td>73610</td>
<td>complete, minimum of three views</td>
</tr>
<tr>
<td>73620</td>
<td>Radiologic examination, foot; two views</td>
</tr>
<tr>
<td>73630</td>
<td>complete, minimum of three views</td>
</tr>
<tr>
<td>73660</td>
<td>Radiologic examination; toe or toes, minimum of two views</td>
</tr>
</tbody>
</table>

### 9 MISCELLANEOUS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99070</td>
<td>Supplies and materials provided by the podiatrist over and above those usually included with the office visit or other services rendered</td>
</tr>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes</td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (two or more), per 30 minutes</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>T1013</td>
<td>Sign language or oral interpretive services, per 15 minutes</td>
</tr>
</tbody>
</table>