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
https://www.emedny.org/selfhelp/ePACES/PDFS/5010_ePACES_Professional_Real_Time_Claim_Reference_Guide.pdf

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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 (eg, 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 (eg, 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, 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.

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 (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 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/

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/

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 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 microhematrocrit
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 problems(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.

99345 Home visit for the evaluation and management of a new 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, 75 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

17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	second through 14 lesions, each
17004	15 or more lesions
17110	Destruction, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
17111	15 or more lesions
17250	Chemical cauterization of granulation tissue (ie,proud flesh)

6.2 MUSCULOSKELETAL SYSTEM

20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, toes) without ultrasound guidance
20612	Aspiration and/or injection or ganglion cyst(s)
28001	Incision and drainage, bursa, foot
28008	Fasciotomy, foot and/or toe
28010	Tenotomy, subcutaneous, toe; single
28011	multiple
	(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
28022	metatarsophalangeal joint
28024	interphalangeal joint
28090	Excision of lesion, tendon, tendon sheath or capsule (including synovectomy) (cyst or ganglion); foot
28092	toes
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus
28280	Syndactylism, e.g., webbing or Kelikian type procedure
28285	Correction hammertoe; (eg, interphalangeal fusion, partial or total, phalangectomy)
28292	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method
28302	Osteotomy; talus
28304	Osteotomy, tarsal bones, other than calcaneus or talus
28306	Osteotomy, with or without lengthening, shortening or angular correction, first metatarsal
28308	other than first metatarsal
28310	Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

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

64782	foot, except digital nerve
64783	foot, each additional nerve, except same digit

8 RADIOLOGY SERVICES

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

9 MISCELLANEOUS

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