

NEW YORK STATE

MEDICAID PROGRAM

PODIATRY

PROCEDURE CODES

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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.

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:

- marital 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.

3A. 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, and treatments, conferences with or concerning patients, preventive health supervision, 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 (e.g., 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.

3B. 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, e.g., “Hospital Care”, special instructions will be presented preceding the levels of E/M services.

- iii. REVIEW THE LEVEL OF E/M SERVICE DESCRIPTORS AND EXAMPLES 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 (i.e., 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 patient’s problems.
 - Comprehensive – chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint of present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family and social history as well as a comprehensive assessment/history of pertinent risk factors.

- 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

Co-morbidities/underlying disease, 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:**

- For the following categories/subcategories, **ALL OF THE KEY COMPONENTS** (i.e., 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; hospital observation services; initial hospital care; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.
- For the following categories/subcategories, **TWO OF THE THREE KEY COMPONENTS** (i.e., 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.
- In the case where counseling and or coordination of care dominates (more than 50%) the practitioner/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital), then **time** is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record.

4. **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.
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 -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).

7. **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.**
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), 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:

- (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.

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:** The fees are listed in the Podiatry Fee Schedule, available at: <http://www.emedny.org/ProviderManuals/Podiatry/index.html>
Listed fees are the maximum reimbursable Medicaid fees.

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.)

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 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.

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 99202-99205 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 "11". See the Fee Schedule column, FEE OFFICE, for the fees of the office Evaluation and Management services noted below. For services rendered in a Hospital Outpatient setting report place of service "22". See the Fee Schedule column, FEE OUTPT, for the fees of the Hospital Outpatient services, codes 99202-99205 and 99211-99215.

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

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.

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 physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
- 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.

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.

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.

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.

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.

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.

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.

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
- 99239 more than 30 minutes

(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.
- 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.
- 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.
- 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.
- 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.

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.

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

a detailed or comprehensive history;
a detailed or comprehensive examination; and
medical decision making that is straightforward or of low complexity.

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. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

a comprehensive history;
a comprehensive examination; and
medical decision making of moderate complexity.

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. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:

a comprehensive history;
a comprehensive examination; and
medical decision making of high complexity.

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. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

SUBSEQUENT NURSING FACILITY CARE

All levels of subsequent nursing facility 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 physician.

- 99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
a problem focused interval history;
a problem focused examination;
straightforward medical decision making.
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. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.
- 99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
an expanded problem focused interval history;
an expanded problem focused examination;
medical decision making of low complexity.
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. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
- 99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
a detailed interval history;
a detailed examination;
medical decision making of moderate complexity.
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. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
- 99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
a comprehensive interval history;
a comprehensive examination;
medical decision making of high complexity.
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.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

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.

NEW PATIENT

- 99324 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. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.
- 99325 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 low complexity. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
- 99326 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 moderate complexity. Usually, the presenting problem(s) are of moderate to high complexity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.
- 99327 Domiciliary or rest 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 moderate to high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
- 99328 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 patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

ESTABLISHED PATIENT

- 99334 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 focused interval history, a problem focused examination, and/or medical decision making that is straightforward. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.
- 99335 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 low complexity.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336 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 moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

99337 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 comprehensive interval history, a comprehensive examination, and 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 physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

HOME SERVICES

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

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 straightforward medical decision making. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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 low complexity. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.

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 moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

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.

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.

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.

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.

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.

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.

PROLONGED SERVICES WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE VISIT OR OTHER OUTPATIENT SERVICE

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service on the date of primary service, each 15 minutes of total time (List separately in addition to codes 99205,99215 for office or other outpatient Evaluation and Management services)

SURGICAL SERVICES

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)

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)

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

AMPUTATION

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

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

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);
- 29425 walking or ambulatory type
- 29580 Strapping; Unna Boot

PERIPHERAL NERVES

Podiatry Procedure Codes

- 64450 Injection, anesthetic agent; other peripheral nerve or branch
64455 plantar common digital nerve(s) (eg, Morton's neuroma)
(Do not report 64455 in conjunction with 64632)
64632 Destruction by neurolytic agent; plantar common digital nerve
(Do not report 64632 in conjunction with 64455)
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

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

MISCELLANEOUS

- 99070 Supplies and materials provided by the podiatrist over and above those usually included with the office visit or other services rendered
J3490 Unclassified drugs
T1013 Sign language or oral interpretive services, per 15 minutes