OPTUM360™

Coding Companion for Podiatry

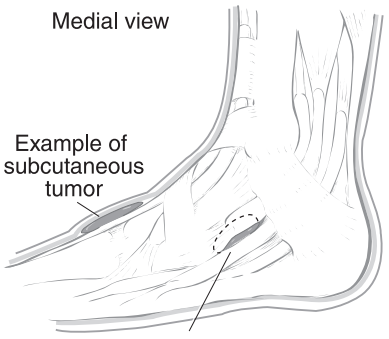
A comprehensive illustrated guide to coding and reimbursement

2016

Contents

28043-28045 [28039, 28041]

28043 Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28039 1.5 cm or greater
28045 Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm
28041 1.5 cm or greater



Report 28043 or 28039 for subcutaneous excision and 28045 or 28041 for subfascial excision of a soft tissue tumor of the foot or toe

Explanation

The physician removes a tumor from the soft tissue of the foot or toe that is located in the subcutaneous tissue in 28039 and 28043 and in the deep soft tissue, below the fascial plane, or within the muscle in 28041 and 28045. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 28043 for excision of a subcutaneous tumor whose resected area is less than 1.5 cm and 28039 for a resected area that is 1.5 cm or greater. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28041 for a resected area 1.5 cm or greater.

Coding Tips

Codes 28039 and 28041 are resequenced codes and will not display in numeric order. Local anesthesia is included in these services. However, these procedures may be performed under general anesthesia, depending on the age and/or condition of the patient. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For radical resection of a tumor, soft tissue of foot, see 28046–28047. For excision of cutaneous, benign lesions, see 11420–11426. Significant exploration of blood vessels, nerve repair, and complex repairs are reported separately.

ICD-9-CM Diagnostic

171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip
172.7 Malignant melanoma of skin of lower limb, including hip
195.5 Malignant neoplasm of lower limb
198.89 Secondary malignant neoplasm of other specified sites
209.34 Merkel cell carcinoma of the lower limb
209.75 Secondary Merkel cell carcinoma
214.1 Lipoma of other skin and subcutaneous tissue
215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

HCPCS Equivalent Codes

N/A

Terms To Know

benign. Mild or nonmalignant in nature.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

lipoma. Benign tumor containing fat cells and the most common of soft tissue lesions, which are usually painless and asymptomatic, with the exception of an angiolipoma.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other areas in the body.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
28039	10.05	14.64	90	A	3(1)
28041	13.19	13.19	90	A	3(1)
28043	7.54	11.53	90	A	-
28045	9.98	14.27	90	A	-

	Modifiers				Medicare Reference
28039	51	50	N/A	80	None
28041	51	50	N/A	80*	
28043	51	50	N/A	N/A	
28045	51	50	N/A	80*	

* with documentation

36415

36415 Collection of venous blood by venipuncture

Explanation

A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection. The blood is used for diagnostic study and no catheter is placed.

73590

73590 Radiologic examination; tibia and fibula, 2 views

Explanation

Two films of the lower leg bones are taken. The physician interprets and reports the findings.

73600-73610

73600 Radiologic examination, ankle; 2 views
73610 complete, minimum of 3 views

Explanation

Two films are taken of the ankle in 73600 and a complete radiologic exam of the ankle is performed in 73610 with three or more films taken. The codes do not specify that a specific view must be performed. The physician interprets and reports the findings.

73615

73615 Radiologic examination, ankle, arthrography, radiological supervision and interpretation

Explanation

The physician injects radiopaque fluid into the ankle for arthrography. The physician inserts a needle into the joint and aspirates if necessary. Opaque contrast solution is injected into the ankle and the needle is removed. Films are then taken of the ankle. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the injection.

73620-73630

73620 Radiologic examination, foot; 2 views
73630 complete, minimum of 3 views

Explanation

Two films are taken of the foot in 73620 and a complete radiologic exam of the foot is performed in 73630 with three or more films taken. The codes do not specify that a specific view must be performed. The physician interprets and reports the findings.

73650

73650 Radiologic examination; calcaneus, minimum of 2 views

Explanation

Two or more films are taken of the calcaneous or heel bone. The physician interprets and reports the findings.

73660

73660 Radiologic examination; toe(s), minimum of 2 views

Explanation

Two or more films are taken of the toes. The physician interprets and reports the findings.

73700-73702

73700 Computed tomography, lower extremity; without contrast material
73701 with contrast material(s)
73702 without contrast material, followed by contrast material(s) and further sections

Explanation

Computed tomography (CT) directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. CT is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the lower extremity. Report 73700 if no contrast is used. Report 73701 if performed with contrast and 73702 if performed first without contrast and again following the injection of contrast.

73718-73720

73718 Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
73719 with contrast material(s)
73720 without contrast material(s), followed by contrast material(s) and further sequences

Explanation

Magnetic resonance imaging (MRI) is a radiation-free, noninvasive, technique to produce high quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. For lower extremity other than joint, report 73718 if no contrast is used; 73719 if performed with contrast; and 73720 if performed first without contrast and then again following the injection of contrast.

73721-73723

73721 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73722 with contrast material(s)
73723 without contrast material(s), followed by contrast material(s) and further sequences

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $33.5 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under "Instructions for Use of the CPT Codebook" on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase "physician or other qualified health care professional" (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)." State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from "clinical staff" and are able to practice independently. CPT defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient's encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient's attending