STATE OF MARYLAND
DHMH
Medical Care Policy Administration
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Maryland Department of Health and Mental Hygiene
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MARYLAND MEDICAL ASSISTANCE PROGRAM
Podiatry Services Transmittal No. 27
June 18, 1999

Podiatrists

FROM: Joseph M Millstone
Director

NOTE: Please ensure that appropriate staff members in your organization are informed about the contents of this transmittal.

Adoption of Proposed Amendments to COMAR 10.09.15
Podiatry Services

ACTION:
Proposed Regulation (Permanent Status)

Effective Date:
June 14, 1999

PROGRAM CONTACT PERSON:
Robert Zielaskiewicz (410) 767-1481

COMMENT PERIOD EXPIRED: 4/26/99

The proposed amendments to Regulations .01, and .04 - .07 under COMAR 10.09.15 Podiatry Services have been approved as proposed in the Maryland Register. These amendments revise the Podiatry Services Provider Fee Manual through 1999 CPT-4 and allow podiatrists to be reimbursed on the same payment basis as physicians and Advanced Practice nurses.

JMM:rz

MARYLAND MEDICAL ASSISTANCE PROGRAM

PODIATRY SERVICES PROVIDER FEE MANUAL

REVISION 1999

Table of Contents

DEFINITIONS

1. **"Emergency services"** means treatment for traumatic injury or infection other than athlete's foot or chronic mycotic infection of the nail bed.

2. **"Personal hygiene care"** means routine hygienic care in the absence of patholgy.

3. **"Podiatrist"** means a Doctor of Podiatry (D.P.M.) who is licensed to practise podiatry by the State Board of Podiatric Medical Examiners or by the state in which the service is rendered.

4. **"Practice podiatry"** means:

(a) To diagnose or surgically, medically or mechanically treat any ailment of the human foot or ankle, or any ailment of the anatomical structures that attach to the human foot; and

(b) Does not include

(i) Surgical treatment of acute ankle fracture; or
(ii) Administration of an anesthetic, other than a local anesthetic.

5. **"Routine podiatric care"** means the cutting or removal of corns and calluses, and the trimming, cutting, clipping or debriding of toenails

PROVIDER REQUIREMENTS

The provider must meet all license requirements as set forth in COMAR 10.09.36.02 (General Medical Assistance Provider Participation Criteria) and all conditions for participation in the Program as set forth in COMAR 10.09.36.03, including:

1. Be licensed and legally authorized to practice podiatry in the state in which the service is provided.

2. Ensure that all Clinical Laboratory Improvement Amendments (CLIA) certification exists for all clinical laboratory services performed, and

(a) If located in Maryland, comply with the requirements of Health-General Article, Title 17, Subtitles 2 and 3, Annotated Code of Maryland and COMAR 10.10.06, or

(b) If located out-of-state, comply with other applicaable standards by the state or locality in which the service is provided

3. Ensure that all X-ray or other radiological equipment is inspected and meets the standards established by COMAR 10.14.03 or other applicable standards established by the state or locality in which the service is provided.

4. Not knowingly employ another podiatrist to provide services to Medical Assistance patients after that podiatrist has been disqualified from the Program.

COVERED SERVICES

The Medical Assistance Program covers the following podiatry services:

1. Medically necessary services, other than routine care, when these services are:

(a) Rendered to a recipient in the podiatrist's office, the recipent's home, a hospital, a nursing facility, a free-standing clinic or elsewhere,

(b) Performed by the podiatrist or another licensed podiatrist in the podiatrist's employ,

(c) Clearly related to the recipient's individual medical needs as diagnostic, curative, palliative or rehabiltative, and

(d) Adequately described in the patient's medical record

2. Office, home, nursing facility or domiciliary visits for routine podiatric care for recipients who are diabetic or who have a vascular disease affecting the lower extremities.

3. Drugs dispensed by the podiatrist in an emergency or drugs which cannot be self-administered within the limitations of COMAR 10.09.03 (Pharmacy Services).

4. Injectable drugs administered by the podiatrist within the limitations of COMAR 10.09.03.

5. Drugs prescribed by the podiatrist within the limitations of COMAR 10.09.03.

6. Medical equipment and supplies prescribed by the podiatrist within the limitations of COMAR 10.09.12 (Disposable Medical Supplies and Durable Medical Equipment).

7 Emergency services and related follow-up care

ROUTINE PODIATRIC CARE

Program reimbursement for routine foot care, the cutting or removal of corns and calluses and the trimming, cutting, clipping or debriding of toenails, is limited to one visit every 60 days for recipients who have diabetes or peripheral vascular diseases that affect the lower extremities, when rendered in the podiatrist's office, the recipient's home, a nursing facility or domiciliary. When billing the Program for

routine care, the name of the physician treating the patient for diabetes or peripheral vascular disease should be entered on line 19 of the HCFA-1500, Reserved for Local Use, followed by the physician's UPIN, and the date that the patient was last seen by this physician. The podiatrist's medical record must also indicate the date that the patient was last seen by this physician. The appropriate ICD-9-CM code indicating that the patient has a condition relating to diabetes or peripheral vascular disease must also be entered in block 21 of the HCFA-1500, Diagnosis or Nature of Illness or Injury, as the primary diagnosis, and the podiatric diagnosis as secondary.

The following CPT-4 Surgery codes are used to bill for routine care for those recipients who qualify: 11055-11057 and 11719. These codes should be used when they are the only services provided. If the podiatric visit includes an history, examination and medical decision making in addition to the routine care, the appropriate CPT-4 Evaluation and Management code should be used instead of these surgical codes. Routine care for those recipients who qualify may be billed separately when provided in conjunction with other medically necessary surgical procedures at the same visit. Routine care cannot be billed in addition to an office visit.

PODIATRIC VISITS

The following CPT-4 Evaluation and Management codes are used to bill for podiatric visits which include the key components of an history, examination and medical decision making:

OFFICE	HOME	NURSING FACILITY	DOMICILIARY
99201-99204 99211-99214	99341 99347	99301-99302,99311	99321,99331

Podiatric visit codes are not to be used if the only service rendered was routine care. Routine care cannot be billed in addition to a podiatric visit.

EMERGENCY SERVICES

"Emergency Services" means treatment for traumatic injury or infection other than athlete's foot or chronic mycotic infection of the nail bed. The procedure codes and fees for emergency services are the same as those for the podiatric visits. Payment is made under these codes only when payment is not being requested under one of the surgical procedure codes. If a patient is treated in the office on an emergency basis but no surgical procedure is performed, the appropriate visit code should be billed; and if a surgical procedure is performed, the code for that procedure should be used instead of the visit code. A podiatrist may include the charges for radiological and laboratory services performed by the podiatrist when used in the treatment of trauma or infection when billing for emergency services. Hospital emergency department services are not covered.

INPATIENT SERVICES

The Podiatry Program does not cover non-surgical hospital visits. Payment will be made only for actual surgical procedures rendered to eligible recipients during the hospital stay. When it is necessary to perform a surgical procedure on an inpatient, Program reimbursement includes all subsequent hospital and office visits associated with the patient's after-care. The administration of local anesthesia for surgery is not covered as a separate charge, but is included in the fee for the surgical procedure.

SURGICAL PROCEDURES

If multiple procedures are performed at the same operative session, the 5-position CPT-4 procedure code must be followed by a 2-position modifier code for all procedures following the first procedure. The major procedure should be reported without a modifier. The modifier "-50" should be used for the second and subsequent procedures. The Program will pay up to the amount listed in the fee schedule for the procedure without the modifier and up to 50% of the amount in the fee schedule for the procedures with the -50 modifier.

When a procedure has a code for both a single procedure and for each additional procedure, use the modifier -50 for the second and subsequent procedures. When only one procedure code is available, regardless of the number of procedures performed, use the same procedure code with the modifier -50 to report the second and subsequent procedures.

When there is no procedure code to identify bilateral procedures use the code for the unilateral procedure plus the same code with a modifier -50 to identify that the procedure was performed bilaterally

AFTERCARE DAYS

Fees for surgical procedures include follow-up care for the number of days indicated in this manual. The Program does not pay the podiatrist for hospital and office visits during the surgical aftercare period. When the follow-up period is listed as "0", the listed value is for the surgical procedure only. All post-operative care in those cases is to be invoiced on a fee-for-service basis.

INJECTABLE DRUGS

The Program reimburses podiatrists for drugs injected in the office or home setting in accordance with the injectable drug codes (J-codes) under COMAR 10.09.02.07 (Physicians' Services). Podiatrists must bill their acquisition cost for injectable drugs. The actual cost must be the charge. The acquisition cost is defined as the purchase price of the drug, less any discounts, for the amount administered, including any portion of shipping and handling. The Program will reimburse the podiatrist at the lower of the podiatrist's actual cost or the Program's

estimated acquisition cost.

When an unlisted injectable drug is administered or the "strength" or amount administered is different from the J-codes listed in this manual, use the unlisted injectable drug code J3490 in Block 24 D of the HCFA-1500 ,and write in the name of the drug, NDC number, and amount administered. The number of units administered in Block 24 G of the HCFA-1500 refers to the maximum allowed under the fee schedule and not the amount actually given. A copy of a current invoice which clearly shows the per unit cost of the drug must be attached to a claim whenever the unlisted injectable drug code J3490 is used. The calculation used to determine the acquisition cost must also be clearly written on the invoice.

SUPPLIES AND MATERIALS

Podiatrists must bill their acquisition cost for supplies and materials provided over and above those usually included in an office visit using procedure code 99070. The acquisition cost is defined as the purchase price of the supply or material, less any discounts, for the amount provided, including any portion of shipping and handling. The name of the supply or material, the product catalog number and the amount given must be clearly written in Block 24 D of the HCFA-1500. A copy of a current invoice which clearly shows the per unit cost of the supply or material provided, including any portion of shipping and handling. must be attached to the claim form. The calculation used to determine the acquisition cost must also be clearly be written on the invoice.

POST-OPERATIVE SURGICAL REVIEW

Post-operative review of podiatric surgical procedures is conducted on a random basis by the Program to ensure that the Program's regulations are being met by the provider. Pre- and post-operative x-rays may be requested as part of the review process.

NON-COVERED SERVICES

The Podiatry Program does not cover the following services:

1. Services not medically necessary,

2. Investigational or experimental drugs or procedures

3. Services prohibited by the Maryland Podiatry Act or the State Board of Podiatric Medical Examiners,

4. Services denied by Medicare as not medically justified,

5. Drugs and supplies which are acquired by the podiatrist at no cost,

6. Injections and visits solely for the administration of injections,

unless medical necessity and the patient's inability to take oral medications are documented in the patient's medical record,

7. More than one visit per day unless adequately documented in the patient's medical record as an emergency,

8. Visits by or to the podiatrist solely for the purpose of the following:

(a) Prescription or drug pick-up,

(b) Collection of specimens for laboratory procedures, except by venipuncture, capillary or arterial puncture, and

(c) Interpretation of laboratory tests or panels,

9. Physical therapy when performed as a podiatric service,

10. Orthotics and inlays of any type and related services,

11. Disposable medical supplies

12. Administration of anesthesia as a separate charge,

13. Corrective shoes,

14. Braces,

15. Personal hygiene care,

16. Routine care, except for recipients who are diabetic or who have a vascular disease affecting the lower extremities,

17. Non-surgical hospital visits,

18. Laboratory or X-ray services not performed by the podiatrist or under the direct supervision of the podiatrist, and

19. Podiatric inpatient hospital services rendered during an admission denied by the Program's utilization control agent or during a period that is in excess of the length of stay authorized by the utilization control agent.

20. The podiatrist may not bill the Program nor the recipient for

(a) Completion of forms and reports,

(b) Broken or missed appointments,

(c) Professional services rendered by mail or telephone,

(d) Services which are provided at no charge to the general public,

and

(e) Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

BILLING TIME LIMITATIONS

Claims must be received within 9 months of the date that services were rendered. If a claim is received within the 9-month limit but rejected due to erroneous or missing data, resubmittal will be accepted within 60 days of rejection or within 9-months of the date that the service was rendered, whichever is later. If a claim is rejected because of late receipt, the recipient may not be billed for that claim.

Medicare/Medicaid Crossover claims must be received within 120 days of the date that payment was made by Medicare. This is the date of Medicare's Explanation of Benefits form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

BY REPORT (B.R.)

When the fee for a surgical procedure is listed as "By Report" (B.R.) in this manual, the value of the procedure is to be determined from a copy of the podiatrist's operative report or notes which must be submitted with the invoice. The report must contain the post-operative diagnosis and the main surgical procedure and supplementary procedure(s).

MAXIMUM REIMBURSEMENT

The Medical Assistance Program has established a fee schedule for covered podiatry services. The fee schedule lists all covered services by CPT-4 code and the maximum fee allowed for each service. The reimbursement rates are in accordance with those established under COMAR 10.09.02.07. Podiatrists must bill their usual and customary charge to the general public. The Program will pay the lower of the podiatrist's usual and customary charge or the Program's fee schedule. Program reimbursement for procedures listed as "By Report" (B.R.) will be determined on an individual basis.

The fees listed in this manual represent the maximum fees allowed for specific procedures. Podiatrists must consider the fee paid by the Medical Assistance Program as payment in full and are prohibited by law from requesting or receiving additional payment from recipients or their families. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the podiatrist may not seek payment for that service from the recipient or family members.

MEDICARE/MEDICAID CROSSOVERS

The Medical Assistance Program is always the payor of last resort Whenever a Medical Assistance recipient is known to be enrolled in Medicare, Medicare must be billed first. Claims for Medicare/Medicaid recipients must be submitted on the HCFA-1500 directly to the Medicare Intermediary.

When billing Medicare on the HCFA-1500 form, place the letters "MMA" (Maryland Medical Assistance) and the recipient's 11-digit identification number in Block 9a and check "Accept Assignment" in Block 27. This will assure that Medicare will automatically forward the appropriate information to the Program which is responsible to pay for the deductible or coinsurance. Also make certain to check both Medicare and Medicaid in Block 1 on the top of the HCFA-1500 so as not to delay any payments due.

PODIATRY SERVICES REIMBURSEMENT

The fee schedule for podiatry services utilizes the codes in the latest revision of the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). This schedule lists all covered podiatry services by CPT-4 code, a short descriptor, the maximum reimbursement and number of aftercare days for surgical procedures. Podiatrists must have access to the latest revision of CPT-4 in order to properly complete the HCFA-1500. The provider must select the procedure code that most accurately identifies the service performed. Any service rendered must be adequately documented in the medical record. The records must be retained for six years. Lack of acceptable documentation may cause the Program to deny payment, or if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit. CPT-4 definitions, and not the short descriptors found in the fee schedule, should be used for assigning codes for billing purposes.

SERVICES AND REIMBURSEMENTS

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
10060	Drainage of skin abscess	15.00	000
10061	Drainage of skin abscess	50.00	000
10120	Remove foreign body	15.00	000
10121	Remove foreign body	40.00	000
10140	Drainage of hematoma/fluid	15.00	000
10160	Puncture drainage of lesion	11.00	000
10180	Complex drainage, wound	32.78	003
11000	Debride infected skin	13.00	000
11010	Debride skin, fx	114.00	010
11011	Debride skin/muscle, fx	136.00	000
11012	Debride skin/muscle/bone, fx	189.00	000
11040	Debride skin partial	11.00	000
11041	Debride skin full	50.00	000
11042	Debride skin/tissue	75.00	000
11043	Debride tissue/muscle	75.00	030
11044	Debride tissue/muscle/bone	125.00	000
11055	Trim skin lesion	10.00	000
11056	Trim 2 to 4 skin lesions	14.00	000
11057	Trim over 4 skin lesions	17.00	000
11100	Biopsy of skin lesion	19.00	000
11200	Removal of skin tags	12.00	000
11305	Shave skin lesion	10.00	000
11306	Shave skin lesion	16.00	000
11307	Shave skin lesion	17.00	000
11308	Shave skin lesion	24.00	000
11420	Removal of skin lesion	31.00	015
11421	Removal of skin lesion	31.00	015
11422	Removal of skin lesion	36.00	015
11423	Removal of skin lesion	41.00	015
11424	Removal of skin lesion	51.00	015
11426	Removal of skin lesion	61.00	015
11620	Removal of skin lesion	42.00	090
11621	Removal of skin lesion	62.00	090
11622	Removal of skin lesion	85.00	090
11623	Removal of skin lesion	125.00	090
11624	Removal of skin lesion	158.00	090
11626	Removal of skin lesion	165.00	090
11719	Trim nail(s)	4.00	000
11720	Debride nail, 1-5	9.00	000
11721	Debride nail, 6 or more	8.00	000
11730	Removal of nail plate	23.00	000
11731	Removal of second nail plate	15.00	000
11732	Remove additional nail plate	13.00	000
11740	Drain blood from under nail	18.00	000
11750	Removal of nail bed	59.00	030
11752	Remove nail bed/finger tip	71.00	030
11755	Biopsy, nail unit	59.00	030

CPT-4 CODES	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
11760	Reconstruction of nail bed	59.00	030
11762	Reconstruction of nail bed	71.00	000
11765	Excision of nail fold, toe	59.00	030
12001	Repair superficial wound(s)	11.00	000
12002	Repair superficial wound(s)	24.00	000
12004	Repair superficial wound(s)	31.00	000
12005	Repair superficial wound(s)	36.00	010
12006	Repair superficial wound(s)	43.00	010
12007	Repair superficial wound(s)	47.00	000
16000	Initial treatment of burn(s)	19.00	000
16010	Treatment of burn(s)	20.00	000
17000	Destroy benign/premal lesion	14.00	000
17003	Destroy 2-14 lesions	6.00	000
17110	Destruct lesion, 1-14	10.00	000
17111	Destruct lesion, 15 or more	15.00	010
20000	Incision of superficial abscess	15.00	000
20005	Incision of deep abscess	85.00	030
20103	Explore wound, extremity	129.00	090
20520	Removal of foreign body	61.00	000
20525	Removal of foreign body	77.00	000
20550	Injection tendon/ligament/cyst	15.00	000
20600	Drain/inject joint/bursa	15.00	000
20605	Drain/inject joint/bursa	18.00	000
20615	Treatment of bone cyst	43.00	007
20900	Removal of bone for graft	210.00	090
20924	Removal of tendon for graft	196.00	090
27650	Repair achilles tendon	259.00	120
27760	Treatment of ankle fracture	70.00	120
27762	Treatment of ankle fracture	83.00	120
27786	Treatment of ankle fracture	58.00	120
27788	Treatment of ankle fracture	70.00	120
27792	Repair of ankle fracture	188.00	120
27899	Unlisted procedure, leg/ankle	B.R.	000
28001	Drainage of bursa of foot	19.00	000
28002	Treatment of foot infection	97.00	000
28003	Treatment of foot infection	95.00	030
28005	Treat foot bone lesion	97.00	030
28008	Incision of foot fascia	44.00	030
28010	Incision of toe tendon	23.00	000
28011	Incision of toe tendons	33.00	000
28020	Exploration of a foot joint	218.00	090
28022	Exploration of a foot joint	86.00	090
28024	Exploration of a toe joint	59.00	090
28030	Removal of foot nerve	143.00	060
28035	Decompression of tibia nerve	209.00	060
28043	Excision of foot lesion	26.00	030
28045	Excision of foot lesion	36.00	030
28046	Resection of tumor, foot	160.00	030
28050	Biopsy of foot joint lining	143.00	090

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
28052	Biopsy of foot joint lining	86.00	090
28054	Biopsy of toe joint lining	59.00	090
28060	Partial removal foot fascia	146.00	090
28062	Removal of foot fascia	218.00	090
28070	Removal of foot joint lining	143.00	090
28072	Removal of foot joint lining	86.00	090
28080	Removal of foot lesion	142.00	060
28086	Excise foot tendon sheath	149.00	090
28088	Excise foot tendon sheath	116.00	090
28090	Removal of foot lesion	94.00	060
28092	Removal of toe lesions	86.00	060
28100	Removal of ankle/heel lesion	143.00	090
28102	Remove/graft foot lesion	168.00	120
28103	Remove/graft foot lesion	155.00	120
28104	Removal of foot lesion	125.00	090
28106	Remove/graft foot lesion	146.00	120
28107	Remove/graft foot lesion	121.00	120
28108	Removal of toe lesions	110.00	090
28110	Partial removal of metatarsal	133.00	090
28111	Partial removal of metatarsal	164.00	090
28112	Partial removal of metatarsal	164.00	090
28113	Partial removal of metatarsal	164.00	090
28114	Removal of metatarsal heads	284.00	090
28116	Revision of foot	168.00	090
28118	Removal of heel bone	116.00	090
28119	Removal of heel spur	151.00	090
28120	Partial removal of ankle/heel	143.00	090
28122	Partial removal of foot bone	170.00	090
28124	Partial removal of toe	132.00	090
28126	Partial removal of toe	132.00	090
28130	Removal of ankle bone	240.00	120
28140	Removal of metatarsal	143.00	090
28150	Removal of toe	122.00	090
28153	Partial removal of toe	122.00	090
28160	Partial removal of toe	122.00	090
28171	Extensive foot surgery	284.00	090
28173	Extensive foot surgery	284.00	090
28175	Extensive foot surgery	284.00	090
28190	Removal of foot foreign body	10.00	000
28192	Removal of foot foreign body	26.00	000
28193	Removal of foot foreign body	113.43	000
28200	Repair of foot tendon	97.00	120
28202	Repair/graft of foot tendon	121.00	120
28208	Repair of foot tendon	49.00	120
28210	Repair/graft of foot tendon	133.00	120
28220	Release of foot tendon	116.00	120
28222	Release of foot tendons	131.00	120
28225	Release of foot tendon	110.00	120
28226	Release of foot tendons	131.00	120

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
28230	Incision of foot tendon(s)	70.00	120
28232	Incision of toe tendon	38.00	120
28234	Incision of foot tendon	38.00	120
28238	Revision of foot tendon	194.00	120
28240	Release of big toe	86.00	090
28250	Revision of foot fascia	116.00	090
28260	Release of midfoot joint	188.00	090
28261	Revision of foot tendon	213.00	090
28262	Revision of foot and ankle	320.00	090
28264	Release of midfoot joint	284.00	090
28270	Release of foot contracture	38.00	060
28272	Release of toe joint, each	31.00	060
28280	Fusion of toes	86.00	060
28285	Repair of hammertoe	88.00	090
28286	Cock-up fifth toe operation	158.00	120
28288	Partial removal of foot bone	59.00	120
28290	Correction of bunion	142.00	120
28292	Correction of bunion	194.00	120
28293	Correction of bunion	194.00	120
28294	Correction of bunion	216.00	120
28296	Correction of bunion	216.00	120
28297	Correction of bunion	216.00	120
28298	Correction of bunion	168.00	120
28299	Correction of bunion, other	B.R.	120
28300	Incision of heel bone	222.00	120
28302	Incision of ankle bone	213.00	120
28304	Incision of midfoot bones	188.00	120
28305	Incise/graft midfoot bones	213.00	120
28306	Incision of metatarsal	164.00	120
28307	Incision of metatarsal	213.00	060
28308	Incision of metatarsal	164.00	120
28309	Incision of metatarsals	150.00	120
28310	Revision of big toe	141.00	120
28312	Revision of toe	145.00	120
28313	Repair deformity of toe	213.00	060
28315	Removal of sesamoid bone	142.00	120
28320	Repair of foot bones	194.00	120
28322	Repair of metatarsals	194.00	120
28340	Resect enlarged toe tissue	213.00	060
28341	Resect enlarged toe	213.00	060
28344	Repair extra toe(s)	213.00	060
28345	Repair webbed toe(s)	213.00	060
28360	Reconstruct cleft foot	B.R.	060
28400	Treatment of heel fracture	88.00	120
28405	Treatment of heel fracture	100.00	120
28406	Treatment of heel fracture	125.00	120
28415	Repair of heel fracture	238.00	120
28420	Repair/graft heel fracture	259.00	120
28430	Treatment of ankle fracture	70.00	120

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
28435	Treatment of ankle fracture	96.00	120
28436	Treatment of ankle fracture	106.00	045
28445	Repair of ankle fracture	240.00	120
28450	Treat midfoot fracture, each	35.00	120
28455	Treat midfoot fracture, each	44.00	120
28456	Repair midfoot fracture	50.00	045
28465	Repair midfoot fracture, each	194.00	120
28470	Treat metatarsal fracture	23.00	000
28475	Treat metatarsal fracture	55.00	120
28476	Repair metatarsal fracture	70.00	045
28485	Repair metatarsal fracture	143.00	120
28490	Treat big toe fracture	23.00	000
28495	Treat big toe fracture	29.00	090
28496	Repair big toe fracture	70.00	015
28505	Repair big toe fracture	97.00	090
28510	Treatment of toe fracture	24.00	090
28515	Treatment of toe fracture	29.00	090
28525	Repair of toe fracture	97.00	090
28530	Treat sesamoid bone fracture	58.00	030
28531	Treat sesamoid bone fracture	143.00	090
28540	Treat foot dislocation	58.00	090
28545	Treat foot dislocation	72.00	090
28546	Treat foot dislocation	86.00	090
28555	Repair foot dislocation	190.00	090
28570	Treat foot dislocation	24.00	000
28575	Treat foot dislocation	59.00	090
28576	Treat foot dislocation	83.00	000
28585	Repair foot dislocation	196.00	090
28600	Treat foot dislocation	58.00	090
28605	Treat foot dislocation	72.00	090
28606	Treat foot dislocation	84.00	090
28615	Repair foot dislocation	143.00	090
28630	Treat toe dislocation	53.00	000
28635	Treat toe dislocation	72.00	000
28636	Treat toe dislocation	83.00	000
28645	Repair toe dislocation	122.00	090
28660	Treat toe dislocation	25.00	000
28665	Treat toe dislocation	49.00	000
28666	Treat toe dislocation	83.00	000
28675	Repair of toe dislocation	97.00	090
28705	Fusion of foot bones	444.00	180
28715	Fusion of foot bones	356.00	180
28725	Fusion of foot bones	284.00	180
28730	Fusion of foot bones	259.00	180
28735	Fusion of foot bones	213.00	180
28737	Revision of foot bones	168.00	180
28740	Fusion of foot bones	194.00	120
28750	Fusion of big toe joint	194.00	120
28755	Fusion of big toe joint	122.00	120

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
28760	Fusion of big toe joint	201.00	120
28800	Amputation of midfoot	238.00	120
28805	Amputation through metatarsal	238.00	120
28810	Amputation toe & metatarsal	143.00	090
28820	Amputation of toe	70.00	090
28825	Partial amputation of toe	59.00	090
29345	Application of long leg cast	24.00	002
29405	Apply short leg cast	19.00	002
29425	Apply short leg cast	21.00	002
29440	Addition of walker to cast	18.00	002
29445	Apply rigid leg cast	32.00	090
29450	Application of leg cast	21.00	002
29515	Application lower leg splint	14.00	002
29540	Strapping of ankle	11.00	000
29550	Strapping of toes	6.00	000
29580	Unna boot	15.00	000
29590	Denis-Browne splint strapping	21.00	000
29730	Windowing of cast	13.00	002
29750	Wedging of clubfoot cast	13.00	002
29891	Ankle arthroscopy/surgery	247.00	090
29892	Ankle arthroscopy/surgery	255.00	090
29893	Scope, plantar fasciotomy	142.00	090
29894	Ankle arthroscopy/surgical	163.00	007
29895	Ankle arthroscopy/surgical	168.00	030
29897	Ankle arthroscopy/surgical	168.00	030
29898	Ankle arthroscopy/surgical	168.00	030
29909	Unlisted procedure arthroscopy	B.R.	030
64450	Inj, anesthetic, peripheral	15.00	000
64726	Decompression, plantar nerve	96.00	090
64782	Excision of neuroma, foot	142.00	030
64783	Excision of neuroma, foot, each	60.00	000
64788	Excision of neurofibroma	142.00	030
64795	Biopsy of nerve	51.00	015
73600	Radiologic examination, ankle	9.50	000
73610	Radiologic examination, ankle	13.00	000
73615	Radiologic examination, ankle	29.00	000
73620	Radiologic examination, foot	9.50	000
73630	Radiologic examination, foot	13.00	000
73650	Radiologic examination, calcaneus	9.50	000
73660	Radiologic examination, toe(s)	8.50	000
99070	Supplies/Materials	B.R	000
99201	Office/outpatient visit, new	25.00	000
99202	Office/outpatient visit, new	33.00	000
99203	Office/outpatient visit, new	37.00	000
99204	Office/outpatient visit, new	48.00	000
99211	Office/outpatient visit, est	10.00	000
99212	Office/outpatient visit, est	20.00	000
99213	Office/outpatient visit, est	31.00	000
99214	Office/outpatient visit, est	38.00	000

CPT-4 CODE	DEFINITION	MAXIMUM PAYMENT	AFTERCARE DAYS
99301	Nursing facility care	10.50	000
99302	Nursing facility care	11.00	000
99311	Subsequent nursing facility care	10.50	000
99321	Domiciliary/rest home visit, new	12.00	000
99331	Domiciliary/rest home visit, est	10.00	000
99341	Home visit, new	33.00	000
99347	Home visit, est	20.00	000

INJECTABLE DRUGS

J-CODE	DESCRIPTION	UNITS
J0702	Betamethasone acetate & sodium phosphate/3 mg	4
J0704	Betamethasone sodium phosphate/4 mg	2
J0810	Cortisone injection	1
J1095	Dexamethosone acetate	1
J1100	Dexamethosone sodium phosphate	1
J1710	Hydrocortisone sodium phosphate	1
J1720	Hydrocortisone sodium succinate	1
J3490	Unclassified (Specify name, NDC, amount admin)	1