2026 CPT Update

LA County Podiatric Medical Association
Present Treasure Hunt Conference

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Learning Objectives

- Identify new programs CMS is planning
- Analyze the MACs expectations regarding documentation
- Gain knowledge of using LCD language to protect our documentation
- Understand the different audits and appeals
- Introduce new services that can ethically enhance office income
- Understand the 2026 changes in rules, regulations, and coding

G2211 Add-on Code

- Visit complexity inherent to E&M associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient single, serious condition or a complex condition.
  - Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established.
  - G2211 is the *accurate* code for complex and comprehensive patient care.
  - As of 1/1/2024, there is payment associated with it

G2211 Add-on Code

- G2211 reflects the time, intensity, and practice expense resources involved when physicians provide outpatient visits that build longitudinal relationships with patients and address the majority of a patient's health care needs with consistency and continuity over longer periods of time.

- Better accounts for the resource costs associated with visit complexity.

G2211 Add-on Code

- Use the add-on code when **you** are the continuing focal point for all healthcare services the patient needs.

- Per CMS, the **relationship** between the patient and the physician is the determining factor of when the add-on code should be billed.

- Medicare Payment Amount for G2211
  - 2026 LA/OC Allowable is $18.64

When to avoid G2211

- Do not use when your relationship with the patient is of a discreet, routine, or time limited nature.
  - Ex: Provider who sees a patient for an acute concern should not report HCPCS G2211 If they have not also assumed responsibility for the patient, ongoing medical care, or do not plan to take responsibility for subsequent, ongoing medical care with consistency and continuity over overtime.
- Avoid if associated office visit E/M is reported with -25 modifier.
- **NOT FOR HOSPITAL VISITS**

Do Private Payers Cover G2211?

- Private payers are not required to cover and pay separately for G2211, and their policies will vary.
  - AAFP encourages providers review contracts and speak with your provider relations representatives about adding G2211 to your fee schedule.

- The AAFP strongly advocates that private payers cover and pay for G2211 across all lines of business.

Skin Cell Suspension Autograft

- Harvesting skin and preparing a suspension of autologous skin cells for spray-on wound application
- New CPT codes introduced for skin harvesting, preparation of skin cell suspension, and spray-on application to wound sites
- Preparation includes enzymatic processing, manual mechanical disaggregation of skin cells, and filtration of the resulting cell suspension.

Skin Cell Suspension Autograft

- CPT 15011 – Harvest of skin for skin cell suspension autograft
  - First 25 sq cm or less
- CPT 15012 – Each add'l 25 sq cm or part thereof (add-on code)

- CPT 15013 – Preparation of skin cell suspension autograft
  - First 25 sq cm or less
- CPT 15014 – Each additional 25 sq cm (add-on code)

15013/15014 only when harvesting skin is manually processed

Application of Skin Cell Suspension Autograft

- Spray-on application of autologous skin cell suspension
- Applied to wound and donor sites
- Includes placement of primary dressing

- CPT 15015 – Application to trunk, arms, or legs
  - First 480 sq cm or less
- CPT 15016 – Each add'l 480 sq cm (add-on code)
- CPT 15017 – Application to head, neck, genitalia, hands, feet
  - First 480 sq cm or less
- CPT 15018 – Each add'l 480 sq cm (add-on code)

Additional Autograft Procedures

- Separate autografts placed prior to skin cell suspension may be reported separately
- Examples include STSG or FTSG
- Use CPT codes 15040–15261 when appropriate.

- If donor site requires a skin graft or local flap repair
  - This may be reported as a separate procedure

Lower Extremity Fascial Plane Block

- Regional anesthesia technique for postoperative pain control
- Needle placed between two fascial layers

- CPT 64473 – Unilateral injection
  - Includes imaging guidance when performed
- CPT 64474 – Continuous infusion technique

Hardware Fixation Augmentation and Orthopedic Implant Movement Analysis

- CPT 0869T – Injection of bone substitute material
  - Used for hardware fixation augmentation
  - Includes intraoperative imaging guidance when performed
- CPT 0946T – Orthopedic implant movement analysis using paired CT examination
  - Includes data acquisition, preparation, transmission, and interpretation
  - Includes paired CT views of the joint or extremity

Real-time Fluorescence Wound Imaging

- CPT code descriptor for 05087 has been revised
- No longer requires non-contact real-time fluorescence wound imaging
- Descriptor now includes work required to create darkness conditions necessary for fluorescence imaging
- Revision accounts for measurement of wound size.
- Procedure may be performed at an anatomic site (i.e. lower extremity)

Add-on Code for Fluorescence Wound Imaging

- Add-on code CPT 0599T reflects a revision to the code
- Includes additional work during imaging procedures.
- Allows measurement and documentation of wound size.
- Allows imaging of additional wound areas during the same session.
- Reported with the primary imaging code.

Selective Debridement

- Removal of burn eschar using enzymatic agents.
- Performed on trunk, arms, or legs.
- Reported based on surface area of burn treated.
- Codes better reflect complexity of burn debridement procedures.

Remote Patient Monitoring

- CPT 99453 represents initial setup of monitoring equipment.
  - Includes patient education on device use
  - Includes instruction for transmitting physiologic data.
  - Typically reported once per episode of care
- CPT 99454 represents supply of remote monitoring devices.
  - Includes daily recording and transmission of physiologic data
  - Examples: weight, blood pressure, pulse oximetry, respiratory flow rate

Remote Patient Monitoring

- CPT 99457 represents treatment management services
  - Includes review of transmitted physiologic data.
  - Includes communication with the patient regarding management.
  - Represents approximately 20 minutes of clinical time per month.
- CPT 99458 is an add-on code
  - Used when monitoring and management exceed the initial 20 minutes.
  - Reported in additional 20-minute increments.

Updated RPM Requirements

- Prior to Jan 1, 2025 RPM device codes required 16 days of monitoring.
- Updated guidelines allow reporting when monitoring occurs for 2 or more days.
- Increases flexibility for providing remote physiologic monitoring services.

E&M Updates

- Updates reduce documentation burden
- Emphasize medical decision making and time-based coding

Recently Deleted Codes

- Nursing Facility Services CPT 99318
- Hospital Observation Services CPT 99217–99220
- Changes align with restructuring of inpatient and observation care reporting

Recently Revised Codes

- Hospital inpatient services CPT 99221–99223
- Hospital discharge services CPT 99238–99239
- Guidelines updated to reflect new documentation standards.

Consultation Code Changes

- Deletion of CPT 99241 and CPT 99251
- Revisions to CPT 99242–99245
- Revisions to CPT 99252–99255
- Documentation guidelines updated for consultation visits.

ED Code Changes

- Emergency department codes CPT 99281–99285 revised
- Guidelines clarify level selection criteria
- Clarify documentation requirements and medical decision making

Domiciliary and Rest Home Code Changes

- Deletion of CPT 99324–99328
- Deletion of CPT 99334–99337
- Deletion of CPT 99339–99340
- Previously described domiciliary or rest home visits

Home and Residence Services Code Changes

- Revisions to CPT 99341 and CPT 99342
- Revisions to CPT 99344 and CPT 99345
- Revisions to CPT 99347–99350
- Codes updated to reflect modern home and residence services

Prolonged Services Codes

- CPT 99354–99357 deleted
- Previously used for prolonged services beyond typical visit times

- CPT 99358 and CPT 99359 revised
- CPT 99415 and CPT 99416 revised
- Guidelines updated for prolonged service reporting.

- CPT 993X0 created for prolonged physician services beyond standard service times.

Definition of Time

- Time is defined as total physician or qualified healthcare professional time spent on the date of service.

- Includes face-to-face and non-face-to-face activities performed that day.

Activities Included in Time

- Reviewing medical records.
- Reviewing diagnostic tests.
- Documenting clinical information.
- Counseling the patient.
- Coordinating care with other providers.

Activities Excluded in Time

- Time spent performing separately reported procedures.
- Services performed by clinical staff.
- Unrelated administrative activities.

MDM Clarifications

- MDM definitions remain consistent with 2021 office visit guidelines.
- CPT clarified definitions such as chronic illness with exacerbation.
- Clarified definitions for drug therapy requiring intensive monitoring.

Key Takeaways

- Updates include revised fluorescence imaging codes.
- New selective enzymatic burn debridement codes.
- Expanded RPM codes CPT 99453–99458.
- Major restructuring of E/M service codes.
- Clarified definitions of time and medical decision making.

Initial Hospital Inpatient/Observation

- An initial service may be reported when the patient has not received professional services from the physician or another physician of the same specialty within the same group during the stay.

Initial Hospital Inpatient/Observation Codes

- CPT 99221 – Initial hospital inpatient/observation care; straightforward or low MDM. Time: 40 minutes.
- CPT 99222 – Initial hospital inpatient/observation care; moderate MDM. Time: 55 minutes.
- CPT 99223 – Initial hospital inpatient/observation care; high MDM. Time: 75 minutes.
- For services ≥90 minutes use prolonged services code 993X0.

Subsequent Hospital Inpatient/Obs Codes

- CPT 99231 – Straightforward/low MDM; time 25 minutes.
- CPT 99232 – Moderate MDM; time 35 minutes.
- CPT 99233 – High MDM; time 50 minutes.
- For services ≥65 minutes use prolonged services code 993X0.

Hospital Inpatient/Observation Same-Day Discharge

- CPT 99234 – Straightforward/low MDM; time 45 minutes.
- CPT 99235 – Moderate MDM; time 70 minutes.
- CPT 99236 – High MDM; time 85 minutes.
- For services ≥100 minutes use prolonged services code 993X0.

Hospital Inpatient/Observation Same-Day Discharge Services

- CPT 99238 – Discharge day management, 30 minutes or less.
- CPT 99239 – Discharge day management, more than 30 minutes.
- For same-day admission/discharge see CPT 99234–99236.

Hospital Inpatient/Observation Consults

- CPT 99252 – Consultation; straightforward MDM. Time 35 minutes.
- CPT 99253 – Consultation; low MDM. Time 45 minutes.
- CPT 99254 – Consultation; moderate MDM. Time 60 minutes.
- CPT 99255 – Consultation; high MDM. Time 80 minutes.
- For services ≥95 minutes use prolonged services code 993X0.

ED Services

- Time is not used to determine ED E/M levels.
- Emergency department care may involve multiple encounters over time.
- No distinction between new and established patients in the ED category.

ED Service Codes

- CPT 99281 – ED visit; may not require physician presence.
- CPT 99282 – ED visit; straightforward MDM.
- CPT 99283 – ED visit; low MDM.
- CPT 99284 – ED visit; moderate MDM.
- CPT 99285 – ED visit; high MDM.

Nursing Facility Services

- Used to report E/M services provided in nursing facilities or skilled nursing facilities.

- May also apply to psychiatric residential treatment centers or intermediate care facilities for individuals with intellectual disabilities.

Initial Nursing Facility Care

- CPT 99304 – Straightforward/low MDM; time 25 minutes.
- CPT 99305 – Moderate MDM; time 35 minutes.
- CPT 99306 – High MDM; time 45 minutes.
- For services ≥60 minutes use prolonged services code 993X0.

Subsequent Nursing Facility Care

- CPT 99307 – Straightforward/low MDM; time 10 minutes.
- CPT 99308 – Low MDM; time 15 minutes.
- CPT 99309 – Moderate MDM; time 30 minutes.
- CPT 99310 – High MDM; time 45 minutes.
- For services ≥60 minutes use prolonged services code 993X0.

Definition of Home or Residence Services

- A home may be a private residence or temporary lodging such as a hotel, campground, hostel, or cruise ship.

- It may also include assisted living facilities, group homes, custodial care facilities, or residential treatment facilities.

Home or Residence Services

- Deletion of domiciliary/rest home E/M codes 99324–99328 and 99334–99337.
- Deletion of home services E/M code 99343.
- Revisions made to codes 99341–99345 and 99347–99350.
- These codes represent services provided in a patient’s home or residence.

Home or Residence Services - Initial

- CPT 99341 – Straightforward MDM; time 15 minutes.
- CPT 99342 – Low MDM; time 30 minutes.
- CPT 99344 – Moderate MDM; time 60 minutes.
- CPT 99345 – High MDM; time 75 minutes.
- For services ≥90 minutes use prolonged services code 99417.

Home or Residence Services - Established

- CPT 99347 – Straightforward MDM; time 20 minutes.
- CPT 99348 – Low MDM; time 30 minutes.
- CPT 99349 – Moderate MDM; time 40 minutes.
- CPT 99350 – High MDM; time 60 minutes.
- For services ≥75 minutes use prolonged services code 99417.

E&M Changes (as of 1/1/2024)

- Updates apply to E/M codes for Office and Other Outpatient Places of Service.
- Changes adjust time thresholds required for code selection beginning January 1, 2024.
- Several CPT codes now require different minimum time thresholds compared with prior guidelines.

Office and Outpatient E&M Codes – Initial

- CPT 99202 – Prior to 1-1-24: 15–29 minutes of total time. Starting 1-1-24: 15 minutes must be met or exceeded.
- CPT 99203 – Prior to 1-1-24: 30–44 minutes of total time. Starting 1-1-24: 30 minutes must be met or exceeded.
- CPT 99204 – Prior to 1-1-24: 45–59 minutes of total time. Starting 1-1-24: 45 minutes must be met or exceeded.
- CPT 99205 – Prior to 1-1-24: 60–74 minutes of total time. Starting 1-1-24: 60 minutes must be met or exceeded.

Office and Outpatient E&M Codes – Established

- CPT 99212 – Prior to 1-1-24: 10–19 minutes of total time. Starting 1-1-24: 10 minutes must be met or exceeded.
- CPT 99213 – Prior to 1-1-24: 20–29 minutes of total time. Starting 1-1-24: 20 minutes must be met or exceeded.
- CPT 99214 – Prior to 1-1-24: 30–39 minutes of total time. Starting 1-1-24: 30 minutes must be met or exceeded.
- CPT 99215 – Prior to 1-1-24: 40–54 minutes of total time. Starting 1-1-24: 40 minutes must be met or exceeded.

SNF E&M Codes – Changes

- CPT 99306 – Prior to 1-1-24: 45 minutes must be met or exceeded.
  Starting 1-1-24: 50 minutes must be met or exceeded.

- CPT 99308 – Prior to 1-1-24: 15 minutes must be met or exceeded.
  Starting 1-1-24: 20 minutes must be met or exceeded.

Place of Service (POS) Overview

- POS codes identify the location where healthcare services are provided.
- Used for billing, reimbursement, and identifying the care setting.
- Differentiate between inpatient, outpatient, and community-based services.

Place of Service (POS) Codes

- 01 — Pharmacy: Facility where medications and medically related items are dispensed to patients.
- 02 — Telehealth Provided Other than in Patient's Home: Telehealth services delivered when the patient is located somewhere other than their residence.
- 03 — School: Facility primarily used for education where healthcare services may also be provided.
- 04 — Homeless Shelter: Temporary housing location providing shelter to homeless individuals or families.

Place of Service (POS) Codes

- 05 — Indian Health Service Freestanding Facility: Provides diagnostic, therapeutic, surgical, and rehabilitation services without hospitalization.
- 06 — Indian Health Service Provider-Based Facility: Services provided to patients admitted as inpatients or outpatients.
- 07 — Tribal 638 Freestanding Facility: Tribal facility providing healthcare services without hospitalization.
- 08 — Tribal 638 Provider-Based Facility: Tribal facility providing services to inpatient or outpatient tribal members.

Place of Service (POS) Codes

- 09 — Prison/Correctional Facility: Facility used for confinement or rehabilitation of criminal offenders.
- 10 — Telehealth Provided in Patient's Home: Telehealth services provided when the patient is located in their residence.
- 11 — Office: Location where healthcare professionals routinely provide evaluation, diagnosis, and treatment.
- 12 — Home: Private residence where a patient receives healthcare services.

Place of Service (POS) Codes

- 13 — Assisted Living Facility: Residential setting with personal assistance and some healthcare services.
- 14 — Group Home: Supervised residence where individuals receive social and limited healthcare services.
- 15 — Mobile Unit: Mobile healthcare facility providing screening, diagnostic, preventive, or treatment services.
- 16 — Temporary Lodging: Short-term accommodations such as hotels, cruise ships, or resorts where care may occur.

Place of Service (POS) Codes

- 17 — Walk-In Retail Health Clinic: Clinic located in a retail setting providing preventive and primary care services.
- 18 — Place of Employment Worksite: Healthcare services provided at a patient’s workplace.
- 19 — Off-Campus Outpatient Hospital: Hospital department located off the main campus providing outpatient services.
- 20 — Urgent Care: Facility providing treatment for acute illness or injury outside the emergency department.

Place of Service (POS) Codes

- 21 — Inpatient Hospital: Hospital where patients receive diagnostic or therapeutic services as admitted inpatients.
- 22 — On-Campus Outpatient Hospital: Outpatient department located on the hospital campus.
- 23 — Emergency Room – Hospital: Area of a hospital where emergency diagnosis and treatment are provided.
- 24 — Ambulatory Surgical Center: Freestanding outpatient facility where surgical and diagnostic services are performed.

Place of Service (POS) Codes

- 25 — Birthing Center: Facility providing labor, delivery, postpartum, and newborn care outside a hospital.
- 26 — Military Treatment Facility: Medical facility operated by the Uniformed Services.
- 27 — Outreach Site / Street: Non-permanent location where healthcare services are delivered to unsheltered individuals.
- Codes 28–30 are currently unassigned.

Place of Service (POS) Codes

- 31 — Skilled Nursing Facility: Facility providing inpatient skilled nursing care and rehabilitation.
- 32 — Nursing Facility: Residential facility providing long-term nursing care.
- 33 — Custodial Care Facility: Facility providing personal assistance without a medical component.
- 34 — Hospice: Facility providing palliative care for terminally ill patients.

Place of Service (POS) Codes

- 41 — Ambulance (Land): Land vehicle equipped and staffed for medical transport.
- 42 — Ambulance (Air or Water): Aircraft or watercraft used for medical transport.
- Codes 43–48 are currently unassigned.

Place of Service (POS) Codes

- 49 — Independent Clinic: Outpatient clinic not part of a hospital.
- 50 — Federally Qualified Health Center: Clinic providing primary care in medically underserved areas.
- 51 — Inpatient Psychiatric Facility: Facility providing inpatient psychiatric services.
- 52 — Psychiatric Facility – Partial Hospitalization: Structured mental health program without full hospitalization.
- 53 — Community Mental Health Center: Facility providing outpatient mental health services, crisis care, and rehabilitation programs.

Place of Service (POS) Codes

- 54 — Intermediate Care Facility for Individuals with Intellectual Disabilities: Facility providing health-related care above custodial level but below hospital/SNF care.
- 55 — Residential Substance Abuse Treatment Facility: Facility providing live-in treatment for alcohol or drug abuse including counseling, therapy, testing, and room/board.
- 56 — Psychiatric Residential Treatment Center: Facility providing 24-hour therapeutic group living and learning environment for psychiatric care.
- 57 — Non-Residential Substance Abuse Treatment Facility: Ambulatory treatment location for alcohol or drug abuse including therapy, counseling, testing, and related services.

Place of Service (POS) Codes

- 58 — Non-Residential Opioid Treatment Facility: Location providing outpatient treatment for opioid dependence using medication-assisted treatment (MAT).

- 59 — Unassigned.

- 60 — Mass Immunization Center: Location where pneumococcal or influenza vaccines are administered, often in mass immunization settings.

Place of Service (POS) Codes

- 61 — Comprehensive Inpatient Rehabilitation Facility: Facility providing intensive rehabilitation services under physician supervision with multidisciplinary therapy.
- 62 — Comprehensive Outpatient Rehabilitation Facility: Facility providing outpatient rehabilitation including physical therapy, occupational therapy, and speech pathology.
- 63–64 — Currently unassigned POS codes.

Place of Service (POS) Codes

- 65 — End-Stage Renal Disease Treatment Facility: Facility providing dialysis treatment and patient training on an ambulatory or home-care basis.
- 66 — Programs of All-Inclusive Care for the Elderly (PACE) Center: Facility providing comprehensive medical and social services for elderly individuals enrolled in PACE programs.
- 67–70 — Unassigned POS codes.
- 71 — Public Health Clinic: Clinic maintained by state or local health departments providing primary medical care.
- 72 — Rural Health Clinic: Certified facility in rural medically underserved areas providing ambulatory primary care services.

Place of Service (POS) Codes

- 73–80 — Currently unassigned POS codes.
- 81 — Independent Laboratory: Laboratory certified to perform diagnostic or clinical tests independent of a physician’s office or institution.
- 82–98 — Unassigned POS codes.
- 99 — Other Place of Service: Location not otherwise identified by another POS code.

Wound Debridement Codes

- Common CPT codes for ulcer and wound debridement include:
  - 11042, 11043, 11044, 11045, 11046, 11047, 97597, and 97598.
- Assistant surgeon services are generally not covered.
- Follow-up days should be verified with MAC/Carrier guidance for wound care and debridement policies.

CPT 11042/11045 – Subcutaneous

- 11042 – Debridement of subcutaneous tissue including epidermis and dermis if performed.
- Reported for the first 20 sq. cm. or less of wound surface area.
- 11045 – Each additional 20 sq. cm. or part thereof.
- Reported separately in addition to the primary code 11042.

CPT 11043/11046 – Muscle/Fascia

- 11043 – Debridement involving muscle and/or fascia.
- Includes epidermis, dermis, and subcutaneous tissue if performed.
- Reported for the first 20 sq. cm. or less.
- 11046 – Each additional 20 sq. cm. or part thereof.
- Reported in addition to code 11043.

CPT 11043/11046 – Muscle/Fascia

- 11043 – Debridement involving muscle and/or fascia.
- Includes epidermis, dermis, and subcutaneous tissue if performed.
- Reported for the first 20 sq. cm. or less.
- 11046 – Each additional 20 sq. cm. or part thereof.
- Reported in addition to code 11043.

CPT 11044/11047 – Bone

- 11044 – Debridement including bone.
- Includes epidermis, dermis, subcutaneous tissue, muscle, or fascia if performed.
- Reported for the first 20 sq. cm. or less.
- 11047 – Each additional 20 sq. cm. or part thereof.
- Reported separately in addition to code 11044.

CPT 97597/97598 – Selective Debridement

- 97597 – Selective debridement including removal of devitalized tissue (e.g., fibrin, biofilm, debris).
- May include high-pressure irrigation, scissors, scalpel, forceps, topical treatments, and wound assessment.
- Reported for the first 20 sq. cm. or less of wound surface area.
- 97598 – Each additional 20 sq. cm. or part thereof.
- Reported in addition to code 97597.

Anesthesia Considerations

- For CPT 11043 and 11044, anesthesia is typically required unless the patient has neuropathy or another neurological condition.

- Medicare carriers often expect these procedures to be performed in a hospital or ambulatory surgery center (ASC).

Medical Record Documentation

- Document wound size, depth, grade, and appearance at each encounter.
- Record measurements both before and after debridement.
- Indicate the type of tissue removed during debridement.

- Document the location of the wound or ulcer.
- Record whether anesthesia was required or not required.
- Specify the instruments used for debridement when appropriate.

Medical Record Documentation

- Include associated factors affecting wound healing such as:
- Poor nutrition, ischemia, diabetes, collagen disease, heart failure, anemia, and wound infection.
- Document the duration of the wound and any local edema or pressure contributing to the condition.
- Debridement exceeding four treatments per wound should be clearly documented as medically necessary.
- Documentation should support treatment for recurrent or multiple ulcers.

CMS Expectations for Debridement

- Most wounds heal within four or fewer debridement sessions.
- More extensive wounds may require debridement every 1–2 weeks.
- Most wounds heal within approximately 16 weeks.

ICD-10/CPT Ulcer Coding Overview

- Ulcer coding requires identification of the underlying condition causing the ulcer.
- Examples include gangrene, lower extremity atherosclerosis, venous disease, diabetic ulcers, or postphlebitic syndrome.

L97.XXX – Chronic Non-Pressure Ulcers

- Ulcer coding requires identification of the underlying condition causing the ulcer.

- Examples include gangrene, lower extremity atherosclerosis, venous disease, diabetic ulcers, or postphlebitic syndrome.

Ulcer Coding – 4th and 5th digit

- 4th Digit - Identifies the anatomical region of the ulcer.
  - .1xx – Thigh
  - .2xx – Calf
  - .3xx – Ankle
  - .4xx – Midfoot or heel
  - .5xx – Other part of the foot.
- 5th Digit - Identifies laterality.
  - .x1x – Right side.
  - .x2x – Left side.

Ulcer Coding – 6th digit (severity)

- .xx1 – Breakdown of skin.
- .xx2 – Fat layer exposed.
- .xx3 – Necrosis of muscle.
- .xx4 – Necrosis of bone.
- .xx5 – Muscle involvement without necrosis.
- .xx6 – Bone involvement without necrosis.
- .xx8 – Other specified severity.
- .xx9 – Unspecified severity.

Pressure Ulcer/Injury Staging

- Stage I – Non-blanchable erythema of intact skin.
- Stage II – Partial thickness skin loss involving epidermis or dermis.
- Stage III – Full thickness skin loss involving subcutaneous tissue.
- Stage IV – Full thickness tissue loss with exposed bone, tendon, or muscle.
- Unstageable – Full thickness skin loss with wound base covered by eschar or slough.
  - True depth cannot be determined until necrotic tissue is removed.

Pressure-Induced Deep Tissue Injury (DTI)

- CMS added a sixth character option '6' in the L89 code series.
- Indicates pressure-induced deep tissue damage.
- Example: L89.626 represents deep tissue damage of the left heel.

Pressure Ulcers vs DTI

- Pressure ulcers involve localized damage to skin and underlying tissue.
- Deep tissue injury represents deeper damage that may precede visible ulcer formation.
- Accurate documentation is required to support the correct ICD-10 classification.

L89.XXX Pressure Ulcers/Injuries

- Pressure ulcers have their own ICD-10 L grouping (L89 series).
- There are similarities between the L89 pressure ulcer codes and the L97 non-pressure ulcer group.
- Pressure ulcers include:
  - Bed sore or decubitus ulcer
  - Plaster ulcer
  - Pressure area or pressure sore.
- When coding pressure ulcers, code first any associated underlying condition such as gangrene (I96).

Exclusions to L89 codes

- Decubitus (trophic) ulcer.
- Ulcer of cervix (uteri) (N86).
- Diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622).
- Non-pressure chronic ulcer of skin (L97 series).
- Skin infections (L00–L08).
- Varicose ulcer (I83.0, I83.2).

L89 Codes – 4th digit

- Identifies the anatomic region of the pressure ulcer.
  - .5xx – Ankle
  - .6xx – Heel
  - .8xx – Other site
  - .9xx – Unspecified site.

L89 Codes – 5th digit

- Indicates laterality of the ulcer.
  - .x1x – Right side
  - .x2x – Left side

L89 Codes – 6th digit

- Identifies stage of the ulcer:
  - .xx0 – Unstageable
  - .xx1 – Healing ulcer stage 1
  - .xx2 – Healing ulcer stage 2
  - .xx3 – Healing ulcer stage 3
  - .xx4 – Healing ulcer stage 4
  - .xx5 – Healing ulcer unstageable
  - .xx6 – Pressure-induced deep tissue damage.

Diabetic Ulcer Coding

- Diabetic ulcers are coded using combination E codes.
- They represent a distinct coding category separate from pressure and non-pressure ulcers.

DM1 with Skin Complications

- E10.62 – Type 1 diabetes mellitus with skin complications.
- E10.621 – Type 1 diabetes mellitus with foot ulcer.
- Use an additional code to identify the site of ulcer (L97.4- or L97.5-).

DM2 with Skin Complications

- E11.62_ – Type 2 diabetes mellitus with skin complications.
- E11.621 – Type 2 diabetes mellitus with foot ulcer.
- Use an additional code to identify the site of ulcer (L97.4- or L97.5-).

Skin Substitutes Policy

- Requirement for ankle–brachial index testing was modified to instead require a vascular assessment.
- Initial proposal limited skin substitute applications per episode to four.
- Final policy allows up to eight skin substitute graft/CTP applications per episode of care when medically necessary **(NCD PAUSED)**
- If more than four medically necessary applications are performed, the KX modifier must be used to indicate medical necessity.

Clinical use of Skin Substitutes

- Skin substitute products with labeled indications may be applied over exposed muscle, tendon, or bone when no contraindications exist.
- Allowed for chronic non-infected diabetic foot ulcers that fail to achieve ≥50% ulcer area reduction after at least four weeks of standard care.
- Also allowed for chronic non-infected venous leg ulcers that fail standard care after four weeks with documented compliance.

CPT 15002-15005 – Surgical Site Prep Codes

- CPT 15002–15005 describe surgical preparation of a clean and viable wound surface.
- These services prepare the wound for placement of a skin substitute graft or negative pressure wound therapy.
- Always verify Local Coverage Determination (LCD) guidance for proper use.

CPT 15002/15003 – Surgical Site Prep

- 15002 – Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar → **Trunk, arms, and legs**
- Includes subcutaneous tissues and incisional release of scar contracture.
- First 100 sq cm (or 1% body surface area in infants/children).
- 15003 – Used for each additional 100 sq cm (or 1% body surface area).
- Reported separately in addition to the primary procedure code.

CPT 15004/15005 – Surgical Site Prep

- 15004 – Surgical preparation or creation of recipient site by excision of wound, burn eschar, or scar → **head, neck, genitalia, hands, feet**
- Includes subcutaneous tissues and incisional release of scar contracture.
- First 100 sq cm.
- 15005 – Add-on code for each additional 100 sq cm (or 1% body surface area).
- Reported separately in addition to the primary procedure code.

Example of Coding for Surgical Site Prep

- Example: Preparation of 250 sq cm wound of the leg.
  - CPT 15002 x 1 reported for the first 100 sq cm.
  - CPT 15003 x 2 reported for additional 150 sq cm

Coding – Skin Substitute Application

- The most commonly used podiatry codes for skin substitute application is CPT 15275
- This code applies to wounds up to 25 sq cm.
- When wound size exceeds this threshold additional units may be required (CPT 15276)

- Other codes may apply
  - Leg/ankle under 100 sq cm = 15271-15272
  - Leg/ankle over 100 sq cm = 15273-15274
  - Foot over 100 sq cm = 15277-15278

Billing Challenge – Skin Substitute Application

- When skin substitute products include the preparation of the wound site, providers cannot bill both the preparation and graft application on the same day of service.

- This creates coding challenges when wound preparation is required prior to graft placement.

Possible Solution to Billing Challenge

- Perform wound preparation prior to the graft application date.
- This ensures the wound is properly prepared before the skin substitute is applied.
- This preparation may occur the day before or earlier depending on clinical need.

Important Coding Reminder

- Read the CPT code description carefully rather than relying only on code numbers.
- CPT 15004 reimburses approximately $400 nationally.
- CPT 15002–15005 should not routinely be used for chronic wound debridement.
- For removal of nonviable tissue in chronic wounds, codes 11042–11047 or 97597–97598 are more appropriate.

Cellular and Tissue-based Products (CTPs) [AKA Skin Substitutes]

- Includes cellular, acellular, and matrix-like products used as scaffolding for tissue repair.
- Products function as a structural support matrix facilitating migration and regeneration of cells.
- Products must be used according to labeled indications and appropriate wound care protocols.

Standard of Care (SOC)

- SOC refers to best practice treatment guidelines defined in the LCD policies.
- Proper wound dressing and wound care are required components.
- Skin substitutes should be used in conjunction with standard wound care practices.

Covered Indications for Skin Substitutes

- Presence of chronic non-infected diabetic foot ulcer failing ≥50% reduction after four weeks of documented standard care.
- Presence of chronic non-infected venous leg ulcer failing four weeks of documented standard care.
- Complete medical history, exam, vascular assessment, and wound documentation must be present.

Documentation Requirement for Skin Subs

- Treatment plan must demonstrate:
  - Debridement as appropriate to achieve a clean granular base.
  - Evidence of infection control.
  - Evidence of sustained compression therapy for venous ulcers.
  - Smoking history documentation and counseling when applicable.

Treatment Failure Criteria

- After four weeks of standard care, lack of improvement must be documented.
- Ulcer measurements must be recorded before and after treatment.
- If ulcer fails to respond after graft placement, additional therapy justification is required.

Medical Record Documentation

- Record must include updated medical history and evaluation of wound prior to graft placement.
- Document planned skin replacement procedure including risks and complications.
- Patient must be under care of a qualified provider addressing the underlying disease process (e.g., diabetes, venous insufficiency, neuropathy).

Coverage Requirement for Skin Subs / CTPs

- Product must be a biologic or synthetic graft material derived from human, animal, or non-human cellular sources.
- High-quality evidence must support safety and effectiveness for DFUs or VLUs.
- Liquid or gel products are not considered grafts because they cannot stabilize on the wound surface.

Skin Subs / CTPs – Reasonable and Necessary

- Maximum of eight applications of skin substitute graft/CTP per episode of care.
- An episode of care is defined as 12–16 weeks from the first application.
- Four applications are standard; additional applications require documentation of medical necessity.

Skin Subs / CTPs – Limitations

- Greater than 8 applications of skin substitute graft/CTP within an episode of care is generally not considered reasonable and necessary.
- Repeated application following unsuccessful grafting without improvement is not considered appropriate.
- Applications in patients with inadequate control of underlying conditions may not be covered (infection, progressive necrosis, active vasculitis, ischemia).

Skin Subs / CTPs – Add'l Coverage Limitations

- Routine surgical preparation services such as debridement are not separately covered when part of routine care.
- Liquid or gel skin substitute preparations are not considered grafts.
- Skin substitute placement on infected, ischemic, or necrotic wound beds is not appropriate.

Medicare Part B – Billing Requirements

- Use appropriate billing forms (CMS-1500 or electronic equivalent).
- Product name, size, and amount used must appear in documentation.
- If the charge reflects invoice cost rather than actual cost, documentation must still be available if requested.

HCPCS Reporting Requirements

- Appropriate HCPCS application codes must be used.
- Units billed must match the amount of skin substitute applied.
- If units billed exceed documented use, the claim may be denied.

Utilization Parameters

- Maximum of 8-10 skin substitute graft/CTP applications per ulcer during an episode of care.
- Episode of care typically spans 12–16 weeks.
- Four applications are standard; additional applications require documentation of medical necessity.

KX Modifier

- The KX modifier indicates that documentation supports medical necessity.
- Used when more than four skin substitute applications are required.
- Use of the KX modifier may trigger additional medical review by payers.

KX Modifier – Documentation Requirements

- Documentation must explain the need for extended therapy.
- Record should show estimated time needed for wound closure.
- Evidence must demonstrate ongoing progress toward healing.
- Treatment plan must address underlying disease processes such as diabetes or venous disease

JW Modifier

- JW modifier identifies the amount of discarded drug or biologic product.
- Used when a portion of the product is wasted and not administered to the patient.
- Required for reporting discarded units according to CMS rules.
- **As of January 1st, 2026, JW modifier is no longer payable except for BLA prodicts**

JZ Modifier

- JZ modifier indicates no discarded amount of the product.
- Used when the entire amount of the product is administered.
- Required for proper reporting beginning July 1, 2023.
- **As of January 1st, 2026, JZ modifier is no longer applicable**

Documentation Requirements

- All services must be documented in the patient's medical record.
- Each encounter should include wound location, measurements, and clinical findings.
- Submitted medical record must support the CPT/HCPCS codes billed.
- Record must explain factors affecting wound healing.
- Documentation should include updated wound measurements and progress evaluation.
- Planned skin substitute therapy and associated risks must be documented.

Documentation Requirements

- Documentation must describe response to treatment and reasons for continued therapy.
- Provider must demonstrate that standard care has been attempted.
- Failure to improve may require reassessment of treatment plan.
- Medical record must include an assessment outlining the treatment plan for the 12–16 week episode of care.
- Plan should describe expectations for wound healing and follow-up evaluations.

Operative Report

- Operative note must support the procedure performed.
- Documentation must include product name, package label information, and wound measurements.
- Relevant clinical findings must be included in the medical record.

Imaging and Wound Measurement Documentation

- Photographs or wound diagrams may be used to document wound size and healing progress.
- Measurements should be recorded at baseline and during follow-up visits.

Wastage Documentation

- If product wastage occurs ***(and needs to be reported)*** documentation must include date, time, and location treated.
- Original package size and discarded amount must be documented.
- Wastage cannot exceed the amount supplied in the package.

HCPCS Units Reporting

- Units billed for skin substitute grafts/CTPs must match the wound description and documented size.

- Billing inconsistencies between HCPCS units and wound measurements may result in claim denial.

Billing Modifier Overview

- Modifiers indicate that a service or procedure has been altered by a specific circumstance.
- Correct use of modifiers ensures appropriate reimbursement and prevents claim denials.
- Anatomic modifiers (-TA, -T1–T9, -LT, -RT) may bypass certain claim edits when appropriate.
- Distinct procedural service modifiers (-58, -59, -78, -79) may also bypass edits when properly documented.

-22 Modifier
Increased Procedural Services

- Used when work required to perform a procedure is substantially greater than typically required.
- Documentation must support additional work and complexity.
- Should NOT be appended to E/M services.

-24 Modifier
Unrelated E/M in Post-operative Period

- Used when an E/M service is performed during the postoperative period for a condition unrelated to the original surgery.

- Allows billing of E/M services during global surgical periods when unrelated to the procedure.

-25 Modifier
Significant Separately Identifiable E/M Service

- Used when a significant E/M service is performed on the same day as another procedure.
- The E/M service must be above and beyond the usual pre- and postoperative care.
- Documentation must support a separate history, exam, and medical decision making.

Additional Common Modifiers

- **-26 Professional Component Only** – used when billing only the physician component (e.g., radiology interpretation).
- **-32 Mandated Services** – used when services are required by a third party (e.g., second opinion).
- **-50 Bilateral Procedure** – used when identical procedures are performed on opposite sides.

Multiple and Reduced Services Modifiers

- **-51 Multiple Procedures** – used when multiple procedures are performed during the same session.
- **-52 Reduced Services** – used when a procedure is partially reduced at physician discretion.
- **-53 Discontinued Procedure** – used when a procedure is terminated due to extenuating circumstances.

Surgical Care Modifiers

- **-54 Surgical Care Only** – physician performs the surgery but not pre/postoperative care.
- **-55 Postoperative Management Only** – physician provides postoperative care only.
- **-56 Preoperative Management Only** – physician performs only the preoperative care.
- **-57 Decision for Surgery** – E/M service resulting in decision to perform major surgery.

Procedure Relationship Modifiers

- **-58 Staged or Related Procedure** – planned or staged procedure during postoperative period.
- **-59 Distinct Procedural Service** – indicates procedures are separate and independent.
- -**76 Repeat Procedure –** by Same Physician.
- **-77 Repeat Procedure –** by Another Physician.

Post-operative Procedure Modifiers

- **-78** Unplanned Return to the Operating Room for a related procedure during postoperative period.

- **-79** Unrelated Procedure During Postoperative Period.

Additional Billing Modifiers

- **-80 Assistant Surgeon** – identifies physician acting as assistant.
- **-90 Outside Laboratory** – laboratory services performed by another lab.
- **-99 Multiple Modifiers** – used when multiple modifiers apply to the same procedure.

Additional Billing Modifiers

- **-GA** – Waiver of Liability Statement on File (ABN).
- **-GY** – Service Statutorily Excluded from Medicare coverage.
- **-GZ** – Item or Service Expected to be Denied as Not Reasonable and Necessary.
- **-KX** – Documentation on File supporting medical necessity.

Podiatry-specific Modifiers

- -LT Left side of body or limb.
- -RT Right side of body or limb.
- Toe modifiers:
  - TA – Left foot great toe
  - T1–T4 – Left toes
  - T5–T9 – Right toes

Changes to -59 Modifier

- CMS created new modifiers to define subsets of the -59 modifier:
    - XE – Separate encounter
    - XS – Separate structure
    - XP – Separate practitioner
    - XU – Unusual non-overlapping service.
- These modifiers should not be reported together with -59 on the same line.

Proper use of -59 Modifier

- Used only on procedure codes, never on E/M codes.
- Indicates a procedure that is distinct or independent from other services on the same day.
- Documentation must support that services were separate and not normally reported together.

Example of -59 Modifier

- Example: CPT 11055 (paring/cutting benign hyperkeratotic lesion) and CPT 11720 (nail debridement).
- Modifier 59 may be used when procedures are performed on separate anatomical structures.
- Modifier should not be used when both services are performed on the same toe.

Clinical Example – Routine Foot Care

- If a mycotic toenail is debrided and a corn/callus is trimmed on the same toe, modifier 59 should NOT be used.

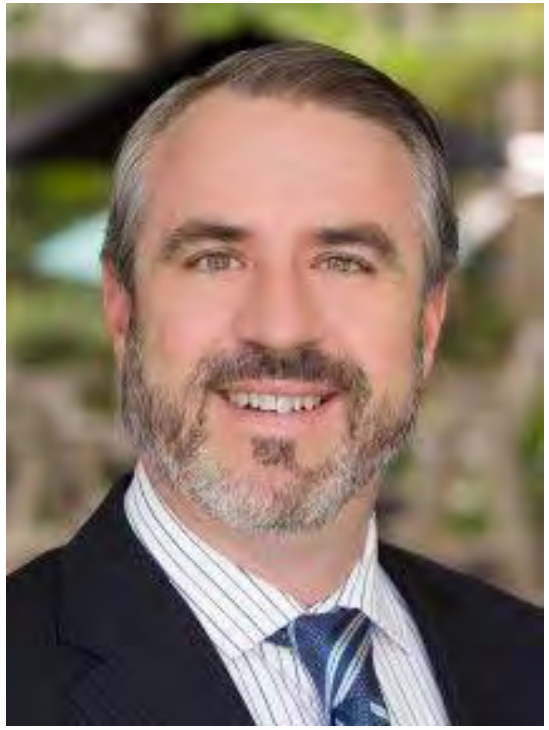
- If procedures are performed on different toes or structures, modifier 59 may be appropriate with documentation.

Routine Foot Care – Appropriate Billing

- Avoid overutilization of 11721 (> 5 nails) with Medicare
- Consider 11720 (< 5 nails) with one total dystrophic nail, G0127
- Payment difference is less than $5.00

- 11730 & 11732 have 8 months between billing.
- 11755: Nail Biopsy can be utilized once a year.

Thank you!



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