

Internal Medicine Coding Alert

Foot Coding: 735.0 or 727.1? Tackle This Condition Terminology for Foot Claims Success

Have these modifiers handy to distinguish areas of the feet and toes.

Don't let anatomic terminology trip up your foot and ankle claims. Learn more about some of the more common foot procedures your internist might face, and you'll be coding those services like an ace.

Build Coding Foundations With Basic Knowledge

Sudden impacts (such as those from jumping during sports) or simple wear-and-tear can cause toe, foot and ankle problems. "You've got to know the differences between these diagnoses, or you may miss a subtle difference and assign the wrong code," says **Heather Corcoran**, coding manager at CGH Billing in Louisville, Ky.

Coding tip: One thing to remember is that you might need modifiers to help differentiate work on different areas of the feet or toes, says **Denise Paige, CPC**, coding and billing manager at Beach Orthopedic Associates in Long Beach, Calif., and the president-elect of the AAPC's Long Beach Chapter. These modifiers include LT (Left side) and RT (Right side), TA-T9 (for the individual toes), and sometimes 59 (Distinct procedural service), depending on the service your physician provides. These modifiers become particularly important if the internist performs the same procedure on more than one foot or toe.

Check Differences Between Bunions and Hallux Valgus

A bunion is an enlargement of bone or tissue around the metatarsophalangeal (MTP) joint of the great toe. It is often caused by patients wearing shoes that are too narrow around the toe box and can cause pain and deformity of the toes.

Keep in mind: A common misconception is that "hallux valgus" and "bunion" refer to the same thing. Although CPT lists bunion procedure codes, such as 28290 (Correction, hallux valgus [bunion], with or without sesamoidectomy; simple exostectomy [e.g., Silver type procedure]), as "hallux valgus corrections," physicians who perform these aren't necessarily correcting a hallux valgus, according to ICD-9 terminology. If you look up 735.0 (Hallux valgus [acquired]), the definition reads, "Angled displacement of the great toe, causing it to ride over or under other toes."

Therefore, you shouldn't report 735.0 unless the patient has an angular deformity of the great toe. According to this definition, a person could have a bunion but not necessarily a hallux valgus deformity, but experts say that the above definition isn't actually followed. Hallux valgus is simply a valgus deformity of the distal great toe (it points laterally) and doesn't have to overlap for a physician to call it hallux valgus.

If the patient's great toe isn't overlapping or impinging upon the second toe, but he still has an obvious bunion, check out 727.1 (Other disorders of synovium, tendon, and bursa; bunion). This code specifically says "bunion," and the ICD-9 definition is "enlarged first metatarsal head due to inflamed bursa; results in laterally displaced great toe." As you can see, this definition does not cover an overlapping toe.

Some coders have used 736.70 (Unspecified deformity of ankle and foot, acquired) to specify a bunion without hallux valgus, but this is incorrect. Because a more specific code is available (727.1), use that instead.

Clarify: Above all, if you've been coding 735.0 -- or even 727.1 -- with all bunionectomies, talk with your physician about the two different ICD-9s, and verify the diagnosis when you see "hallux valgus," because some physicians use this term for all bunion types. Even the CPT text notes "bunion" in parentheses after "hallux valgus," as if to note that they're the same thing.

The most important thing is to check with your payers to see whether this minor discrepancy makes a difference. Although internists don't typically perform bunionectomy, your physician might diagnose a bunion versus hallux valgus and refer the patient to a surgeon.

Verify Injection Rules for Morton's Neuroma, TTS

Morton's neuroma (355.6) is a thickening of the plantar nerve lying between the heads of the metatarsals (most commonly between the third and fourth). Symptoms usually include pain, tingling, burning, and/or numbness in the area. Morton's neuroma can be caused by wearing shoes with a narrow toe box or due to sports.

Physicians conduct a physical exam and often use xrays to diagnose a Morton's neuroma. Rest, orthotics, nonsteroidal anti-inflammatory drugs (NSAIDs), and changing shoes normally will help alleviate the patient's pain, but corticosteroid injections may be necessary. In some cases, the internist might refer the patient to a surgeon for excising the neuroma surgically (28080, Excision, interdigital [Morton] neuroma, single, each).

Compression or entrapment of the posterior tibial nerve causes tarsal tunnel syndrome (TTS, 355.5). This condition is similar to carpal tunnel syndrome in the wrist, but causes pain and numbness at the bottom of the foot. Excessive standing on the feet, varicose veins, bone spurs, athletic injuries, and other issues can cause tarsal tunnel syndrome.

Physicians rely on a physical exam to diagnose TTS, usually along with studies including electromyography (95860-95872) or nerve conduction studies (95900-95905). Once the physician confirms the diagnosis, she will usually begin conservative treatments such as injections, NSAIDs, rest, and footwear changes. In some cases, however, the patient may require surgery. The most common surgical treatment is a tarsal tunnel release (28035).

Watch out: Insurers differ on coding regulations for tarsal tunnel and Morton's neuroma injections. For example, Noridian Medicare advises practices to report the unlisted-procedure code 28899 (Unlisted procedure, foot or toes) for these services. HealthNow's policy advises practices to report 20550 (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]).

Bottom line: Check with your insurer to determine its tarsal tunnel and Morton's neuroma injection requirements.

PTTD, Plantar Fasciitis May Require Surgery

Posterior tibial tendon dysfunction (PTTD) occurs when the posterior tibial tendon becomes inflamed, stretched out, or torn because of wear-and-tear or a sudden injury. Symptoms include pain, swelling, tenderness, and possible flattening of the foot. Physicians can usually diagnose this condition using a physical exam, x-ray, or MRI, Corcoran says.

Physicians typically attempt to repair this condition by prescribing rest, NSAIDs, and possibly casting or bracing. In some cases, surgery such as tenosynovectomy (27680), gastrocnemius recession (27687), tendon transfer (27691), calcaneal osteotomy (28300), or triple arthrodesis (28715) may be required. Your internist will refer the patient to an orthopedic surgeon for these procedures.

Plantar fasciitis (728.71) describes heel pain caused by inflammation of the plantar fascia. Physicians describe a variety of sources of this condition, including athletics without appropriate warm-up, stress on the arch, ill-fitting shoes, and sports-related stress on the heel.

Physicians can usually diagnose plantar fasciitis during a physical exam. Treatments may include NSAIDs, rest, new shoes or shoe orthotics, physical therapy, or injections. In some cases, physicians have success with extracorporeal shock wave therapy (ESWT, 28890) for this condition. If these treatments fail, the physician might refer the patient for surgery, such as an endoscopic plantar fascia release (29893) or an open plantar fascia release (such as 28060, 28062 or 28250). The open procedure is still much more common.