Local Coverage Article:
Billing and Coding: Treatment of Ulcers & Symptomatic Hyperkeratoses (A57459)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

Article Information

General Information

Article ID
A57459

Article Title
Billing and Coding: Treatment of Ulcers & Symptomatic Hyperkeratoses

Article Type
Billing and Coding

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
10/01/2019

Revision Effective Date
N/A

Revision Ending Date
N/A

Retirement Date
N/A

CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862 (a) (1) (A). This section allows coverage and payment only for those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury

or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862(a)(13) of the Act excludes payment for the treatment of flat foot conditions, the treatment of subluxation of the foot, and routine foot care (Medicare Benefit Policy Manual, Chapter 16, Section 30 and Chapter 15, Section 290).

Article Guidance

Article Text:

The following billing and coding guidance is to be used with its associated Local Coverage Determination (LCD).

Coding Guidelines:

While this policy primarily addresses disease of the foot and lower extremity the policy includes skin ulcers and hyperkeratosis on other body parts.

The management of a **symptomatic** hyperkeratosis may involve medical treatment, paring or cutting, shaving, excision, or destruction. This policy addresses only the paring or cutting approach.

This policy does not address treatment of burns or debridement of nails. For treatment of burns, including debridement, refer to the CPT 16000 series. For debridement of nails, refer to CPT codes 11720 and 11721.

When the only service provided is the non-surgical cleansing of the ulcer site with or without the application of a surgical dressing, the provider should bill this service with the appropriate evaluation and management (E/M) code and not bill a debridement code(s).

CPT codes 11042-11043, 97597 and 97598 describe debridement of relatively localized areas with or without their contiguous underlying structures. These codes are appropriate for treatment of skin ulcers, circumscribed dermal infections, conditions affecting contiguous deeper structures, and debridement of ground-in dirt such as from road abrasions.

CPT codes 11042-11047 do not refer solely to ulcer size, but also to levels of actual tissue debridement levels (based on tissue type; e.g., partial skin, full thickness skin, subcutaneous tissue, etc.) of independent (noncontiguous) skin and other deeper tissue structures.

When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of wounds that are the same depth, but do not combine wounds from different depths. This A/B MAC allows payment for an aggregate total of one independent tissue debridement on a given day of service. **Any number greater than the aggregate total of four for one or both feet per date of service will result in a denial which may be appealed with documentation justifying the additional services.** Once debridement is properly done repeat debridement is not expected for several days afterward.

CPT 97597 and 97598 may be used for the medically reasonable and necessary debridement with utilization

consistent with this LCD and within scope of practice of the performing provider.

Consultation services rendered by a podiatrist in a skilled nursing facility are covered if the services are reasonable and necessary and do not come within any of the specific statutory exclusions (NCD 70.2).

Documentation Guidelines:

As is the case in all unusual and complicated procedures, the use of Modifier 22 may be appropriate to report and describe inordinately complex services performed. When used, the procedure note should contain a separate section that describes the "unusual" nature of the procedure.

When addressing a specific toe(s) or finger(s) use the respective CPT® HCPCS Level II modifier to identify them on the claim. Other modifiers may include (but are not to be used alone when the more specific above modifiers are needed to clarify the procedure):

- LT - Left
- RT - Right
- 59 - Independent Anatomical Site
- XE - Separate encounter
- XS - Separate Structure
- XP - Separate Practitioner
- XU - Unusual Non-Overlapping Service

The clinical record must document the indications for the debridement (the presence of necrotic or devitalized tissue), and the size, location, observed depth of the ulcer(s), and the specific depth/level of debridement performed.

The clinical record must document the relevant history and physical findings that justify the diagnoses and procedures claimed. Additionally, the specific location, such as on which specific toe or finger and where must be documented. This requirement is particularly important when the physician claims multiple procedures on different toes of the same foot or fingers of the same hand.

The medical record must be made available to Medicare upon request.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

Lack of documentation to support reasonable and necessary indications for debridement of the ulcer will result in claim denial.

Associated Information:

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

CPT/HCPCS Codes 11055, 11056, 11057, G0127, 11719, 11720, and 11721 may be used to provide routine foot

care. Claims for those procedures will be allowed under the routine foot care benefit when the claims include the appropriate diagnoses and modifiers.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
11042	Deb subq tissue 20 sq cm/<
11043	Deb musc/fascia 20 sq cm/<
11044	Deb bone 20 sq cm/<
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11055	Trim skin lesion
11056	Trim skin lesions 2 to 4
11057	Trim skin lesions over 4
97597	Rmvl devital tis 20 cm/<
97598	Rmvl devital tis addl 20cm/<

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

Note: Diagnosis codes are based on the current ICD-10-CM codes that are effective at the time of LCD publication. Any updates to ICD-10-CM codes will be reviewed by Noridian, and coverage should not be presumed until the results of such review have been published/posted.

These are the **only** covered ICD-10-CM codes that support medical necessity:

For CPT codes 11042-11047, 97597 and 97598, the claim must have at least one of the following

diagnosis codes:

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
E10.620*	Type 1 diabetes mellitus with diabetic dermatitis
E10.621*	Type 1 diabetes mellitus with foot ulcer
E10.622*	Type 1 diabetes mellitus with other skin ulcer
E10.628*	Type 1 diabetes mellitus with other skin complications
E10.65*	Type 1 diabetes mellitus with hyperglycemia
E10.69*	Type 1 diabetes mellitus with other specified complication
E11.620*	Type 2 diabetes mellitus with diabetic dermatitis
E11.621*	Type 2 diabetes mellitus with foot ulcer
E11.622*	Type 2 diabetes mellitus with other skin ulcer
E11.628*	Type 2 diabetes mellitus with other skin complications
E11.65*	Type 2 diabetes mellitus with hyperglycemia
E11.69*	Type 2 diabetes mellitus with other specified complication
I70.231	Atherosclerosis of native arteries of right leg with ulceration of thigh
I70.232	Atherosclerosis of native arteries of right leg with ulceration of calf
I70.233	Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.234	Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
I70.235	Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.238	Atherosclerosis of native arteries of right leg with ulceration of other part of lower leg
I70.239	Atherosclerosis of native arteries of right leg with ulceration of unspecified site
I70.241	Atherosclerosis of native arteries of left leg with ulceration of thigh
I70.242	Atherosclerosis of native arteries of left leg with ulceration of calf
I70.243	Atherosclerosis of native arteries of left leg with ulceration of ankle
I70.244	Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot
I70.245	Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.248	Atherosclerosis of native arteries of left leg with ulceration of other part of lower leg
I70.249	Atherosclerosis of native arteries of left leg with ulceration of unspecified site
I70.25	Atherosclerosis of native arteries of other extremities with ulceration
I70.261	Atherosclerosis of native arteries of extremities with gangrene, right leg

ICD-10 CODE	DESCRIPTION
I70.262	Atherosclerosis of native arteries of extremities with gangrene, left leg
I70.263	Atherosclerosis of native arteries of extremities with gangrene, bilateral legs
I70.268	Atherosclerosis of native arteries of extremities with gangrene, other extremity
I70.269	Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity
I83.011	Varicose veins of right lower extremity with ulcer of thigh
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle
I83.014	Varicose veins of right lower extremity with ulcer of heel and midfoot
I83.015	Varicose veins of right lower extremity with ulcer other part of foot
I83.018	Varicose veins of right lower extremity with ulcer other part of lower leg
I83.021	Varicose veins of left lower extremity with ulcer of thigh
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel and midfoot
I83.025	Varicose veins of left lower extremity with ulcer other part of foot
I83.028	Varicose veins of left lower extremity with ulcer other part of lower leg
I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation

ICD-10 CODE	DESCRIPTION
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I87.011	Postthrombotic syndrome with ulcer of right lower extremity
I87.012	Postthrombotic syndrome with ulcer of left lower extremity
I87.013	Postthrombotic syndrome with ulcer of bilateral lower extremity
I87.031	Postthrombotic syndrome with ulcer and inflammation of right lower extremity
I87.032	Postthrombotic syndrome with ulcer and inflammation of left lower extremity
I87.033	Postthrombotic syndrome with ulcer and inflammation of bilateral lower extremity
I87.311	Chronic venous hypertension (idiopathic) with ulcer of right lower extremity
I87.312	Chronic venous hypertension (idiopathic) with ulcer of left lower extremity
I87.313	Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity
I87.331	Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity
I87.332	Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity
I87.333	Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity
I96*	Gangrene, not elsewhere classified
K12.2	Cellulitis and abscess of mouth
K62.6	Ulcer of anus and rectum
L03.011	Cellulitis of right finger
L03.012	Cellulitis of left finger
L03.031	Cellulitis of right toe
L03.032	Cellulitis of left toe
L03.111	Cellulitis of right axilla
L03.112	Cellulitis of left axilla
L03.113	Cellulitis of right upper limb
L03.114	Cellulitis of left upper limb
L03.115	Cellulitis of right lower limb
L03.116	Cellulitis of left lower limb
L03.211	Cellulitis of face
L03.221	Cellulitis of neck
L03.222	Acute lymphangitis of neck

ICD-10 CODE	DESCRIPTION
L03.311	Cellulitis of abdominal wall
L03.312	Cellulitis of back [any part except buttock]
L03.313	Cellulitis of chest wall
L03.314	Cellulitis of groin
L03.315	Cellulitis of perineum
L03.316	Cellulitis of umbilicus
L03.317	Cellulitis of buttock
L03.811	Cellulitis of head [any part, except face]
L05.01	Pilonidal cyst with abscess
L08.0	Pyoderma
L08.89	Other specified local infections of the skin and subcutaneous tissue
L12.0	Bullous pemphigoid
L59.8	Other specified disorders of the skin and subcutaneous tissue related to radiation
L73.8	Other specified follicular disorders
L89.012	Pressure ulcer of right elbow, stage 2
L89.013	Pressure ulcer of right elbow, stage 3
L89.014	Pressure ulcer of right elbow, stage 4
ICD-10 CODE	DESCRIPTION
L89.016	Pressure-induced deep tissue damage of right elbow
L89.022	Pressure ulcer of left elbow, stage 2
L89.023	Pressure ulcer of left elbow, stage 3
L89.024	Pressure ulcer of left elbow, stage 4
L89.026	Pressure-induced deep tissue damage of left elbow
L89.112	Pressure ulcer of right upper back, stage 2
L89.113	Pressure ulcer of right upper back, stage 3
L89.114	Pressure ulcer of right upper back, stage 4
L89.116	Pressure-induced deep tissue damage of right upper back
L89.122	Pressure ulcer of left upper back, stage 2
L89.123	Pressure ulcer of left upper back, stage 3
L89.124	Pressure ulcer of left upper back, stage 4
L89.126	Pressure-induced deep tissue damage of left upper back
L89.132	Pressure ulcer of right lower back, stage 2

ICD-10 CODE	DESCRIPTION
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.136	Pressure-induced deep tissue damage of right lower back
L89.142	Pressure ulcer of left lower back, stage 2
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.146	Pressure-induced deep tissue damage of left lower back
L89.152	Pressure ulcer of sacral region, stage 2
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.156	Pressure-induced deep tissue damage of sacral region
L89.212	Pressure ulcer of right hip, stage 2
L89.213	Pressure ulcer of right hip, stage 3
L89.214	Pressure ulcer of right hip, stage 4
L89.216	Pressure-induced deep tissue damage of right hip
L89.222	Pressure ulcer of left hip, stage 2
L89.223	Pressure ulcer of left hip, stage 3
L89.224	Pressure ulcer of left hip, stage 4
L89.226	Pressure-induced deep tissue damage of left hip
L89.312	Pressure ulcer of right buttock, stage 2
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.316	Pressure-induced deep tissue damage of right buttock
L89.322	Pressure ulcer of left buttock, stage 2
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.326	Pressure-induced deep tissue damage of left buttock
L89.42	Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.46	Pressure-induced deep tissue damage of contiguous site of back, buttock and hip
L89.512	Pressure ulcer of right ankle, stage 2

ICD-10 CODE	DESCRIPTION
L89.513	Pressure ulcer of right ankle, stage 3
L89.514	Pressure ulcer of right ankle, stage 4
L89.516	Pressure-induced deep tissue damage of right ankle
L89.522	Pressure ulcer of left ankle, stage 2
L89.523	Pressure ulcer of left ankle, stage 3
L89.524	Pressure ulcer of left ankle, stage 4
L89.526	Pressure-induced deep tissue damage of left ankle
L89.612	Pressure ulcer of right heel, stage 2
L89.613	Pressure ulcer of right heel, stage 3
L89.614	Pressure ulcer of right heel, stage 4
L89.616	Pressure-induced deep tissue damage of right heel
L89.622	Pressure ulcer of left heel, stage 2
L89.623	Pressure ulcer of left heel, stage 3
L89.624	Pressure ulcer of left heel, stage 4
L89.626	Pressure-induced deep tissue damage of left heel
L89.812	Pressure ulcer of head, stage 2
L89.813	Pressure ulcer of head, stage 3
L89.814	Pressure ulcer of head, stage 4
L89.816	Pressure-induced deep tissue damage of head
L89.892	Pressure ulcer of other site, stage 2
L89.893	Pressure ulcer of other site, stage 3
L89.894	Pressure ulcer of other site, stage 4
L89.896	Pressure-induced deep tissue damage of other site
L97.111*	Non-pressure chronic ulcer of right thigh limited to breakdown of skin
L97.112*	Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.113*	Non-pressure chronic ulcer of right thigh with necrosis of muscle
L97.114*	Non-pressure chronic ulcer of right thigh with necrosis of bone
L97.115*	Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
L97.116*	Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis
L97.118*	Non-pressure chronic ulcer of right thigh with other specified severity

ICD-10 CODE	DESCRIPTION
L97.121*	Non-pressure chronic ulcer of left thigh limited to breakdown of skin
L97.122*	Non-pressure chronic ulcer of left thigh with fat layer exposed
L97.123*	Non-pressure chronic ulcer of left thigh with necrosis of muscle
L97.124*	Non-pressure chronic ulcer of left thigh with necrosis of bone
L97.125*	Non-pressure chronic ulcer of left thigh with muscle involvement without evidence of necrosis
L97.126*	Non-pressure chronic ulcer of left thigh with bone involvement without evidence of necrosis
L97.128*	Non-pressure chronic ulcer of left thigh with other specified severity
L97.211*	Non-pressure chronic ulcer of right calf limited to breakdown of skin
L97.212*	Non-pressure chronic ulcer of right calf with fat layer exposed
L97.213*	Non-pressure chronic ulcer of right calf with necrosis of muscle
L97.214*	Non-pressure chronic ulcer of right calf with necrosis of bone
L97.215*	Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
L97.216*	Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
L97.218*	Non-pressure chronic ulcer of right calf with other specified severity
L97.221*	Non-pressure chronic ulcer of left calf limited to breakdown of skin
L97.222*	Non-pressure chronic ulcer of left calf with fat layer exposed
L97.223*	Non-pressure chronic ulcer of left calf with necrosis of muscle
L97.224*	Non-pressure chronic ulcer of left calf with necrosis of bone
L97.225*	Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis
L97.226*	Non-pressure chronic ulcer of left calf with bone involvement without evidence of necrosis
L97.228*	Non-pressure chronic ulcer of left calf with other specified severity
L97.311*	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
L97.312*	Non-pressure chronic ulcer of right ankle with fat layer exposed
L97.313*	Non-pressure chronic ulcer of right ankle with necrosis of muscle
ICD-10 CODE	DESCRIPTION
L97.314*	Non-pressure chronic ulcer of right ankle with necrosis of bone
L97.315*	Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis

ICD-10 CODE	DESCRIPTION
L97.316*	Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
L97.318*	Non-pressure chronic ulcer of right ankle with other specified severity
L97.321*	Non-pressure chronic ulcer of left ankle limited to breakdown of skin
L97.322*	Non-pressure chronic ulcer of left ankle with fat layer exposed
L97.323*	Non-pressure chronic ulcer of left ankle with necrosis of muscle
L97.324*	Non-pressure chronic ulcer of left ankle with necrosis of bone
L97.325*	Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis
L97.326*	Non-pressure chronic ulcer of left ankle with bone involvement without evidence of necrosis
L97.328*	Non-pressure chronic ulcer of left ankle with other specified severity
L97.411*	Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
L97.412*	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97.413*	Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
L97.414*	Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone
L97.415*	Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
L97.416*	Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
L97.418*	Non-pressure chronic ulcer of right heel and midfoot with other specified severity
L97.421*	Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin
L97.422*	Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
L97.423*	Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle
L97.424*	Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone
L97.425*	Non-pressure chronic ulcer of left heel and midfoot with muscle involvement without evidence of necrosis
L97.426*	Non-pressure chronic ulcer of left heel and midfoot with bone involvement without evidence of necrosis
L97.428*	Non-pressure chronic ulcer of left heel and midfoot with other specified severity
L97.511*	Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin
L97.512*	Non-pressure chronic ulcer of other part of right foot with fat layer exposed
L97.513*	Non-pressure chronic ulcer of other part of right foot with necrosis of muscle
L97.514*	Non-pressure chronic ulcer of other part of right foot with necrosis of bone

ICD-10 CODE	DESCRIPTION
L97.515*	Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis
L97.516*	Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
L97.518*	Non-pressure chronic ulcer of other part of right foot with other specified severity
L97.521*	Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
L97.522*	Non-pressure chronic ulcer of other part of left foot with fat layer exposed
L97.523*	Non-pressure chronic ulcer of other part of left foot with necrosis of muscle
L97.524*	Non-pressure chronic ulcer of other part of left foot with necrosis of bone
L97.525*	Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
L97.526*	Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
L97.528*	Non-pressure chronic ulcer of other part of left foot with other specified severity
L97.811*	Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin
L97.812*	Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed
L97.813*	Non-pressure chronic ulcer of other part of right lower leg with necrosis of muscle
L97.814*	Non-pressure chronic ulcer of other part of right lower leg with necrosis of bone
L97.815*	Non-pressure chronic ulcer of other part of right lower leg with muscle involvement without evidence of necrosis
L97.816*	Non-pressure chronic ulcer of other part of right lower leg with bone involvement without evidence of necrosis
L97.818*	Non-pressure chronic ulcer of other part of right lower leg with other specified severity
L97.821*	Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin
L97.822*	Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed
L97.823*	Non-pressure chronic ulcer of other part of left lower leg with necrosis of muscle
L97.824*	Non-pressure chronic ulcer of other part of left lower leg with necrosis of bone
L97.825*	Non-pressure chronic ulcer of other part of left lower leg with muscle involvement without evidence of necrosis
L97.826*	Non-pressure chronic ulcer of other part of left lower leg with bone involvement without evidence of necrosis
L97.828*	Non-pressure chronic ulcer of other part of left lower leg with other specified

ICD-10 CODE	DESCRIPTION
	severity
L97.911*	Non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin
L97.912*	Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed
L97.913*	Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of muscle
L97.914*	Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of bone
L97.915*	Non-pressure chronic ulcer of unspecified part of right lower leg with muscle involvement without evidence of necrosis
L97.916*	Non-pressure chronic ulcer of unspecified part of right lower leg with bone involvement without evidence of necrosis
L97.918*	Non-pressure chronic ulcer of unspecified part of right lower leg with other specified severity
L97.921*	Non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin
L97.922*	Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed
L97.923*	Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle
L97.924*	Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of bone
L97.925*	Non-pressure chronic ulcer of unspecified part of left lower leg with muscle involvement without evidence of necrosis
L97.926*	Non-pressure chronic ulcer of unspecified part of left lower leg with bone involvement without evidence of necrosis
L97.928*	Non-pressure chronic ulcer of unspecified part of left lower leg with other specified severity
L98.411*	Non-pressure chronic ulcer of buttock limited to breakdown of skin
L98.412*	Non-pressure chronic ulcer of buttock with fat layer exposed
L98.413*	Non-pressure chronic ulcer of buttock with necrosis of muscle
L98.414*	Non-pressure chronic ulcer of buttock with necrosis of bone
L98.415*	Non-pressure chronic ulcer of buttock with muscle involvement without evidence of necrosis
L98.416*	Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis

ICD-10 CODE	DESCRIPTION
L98.418*	Non-pressure chronic ulcer of buttock with other specified severity
L98.421*	Non-pressure chronic ulcer of back limited to breakdown of skin
L98.422*	Non-pressure chronic ulcer of back with fat layer exposed
L98.423*	Non-pressure chronic ulcer of back with necrosis of muscle
L98.424*	Non-pressure chronic ulcer of back with necrosis of bone
L98.425*	Non-pressure chronic ulcer of back with muscle involvement without evidence of necrosis
L98.426*	Non-pressure chronic ulcer of back with bone involvement without evidence of necrosis
L98.428*	Non-pressure chronic ulcer of back with other specified severity
L98.491*	Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin
L98.492*	Non-pressure chronic ulcer of skin of other sites with fat layer exposed
L98.493*	Non-pressure chronic ulcer of skin of other sites with necrosis of muscle
L98.494*	Non-pressure chronic ulcer of skin of other sites with necrosis of bone
L98.495*	Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis
L98.496*	Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis
L98.498*	Non-pressure chronic ulcer of skin of other sites with other specified severity
S01.00XA	Unspecified open wound of scalp, initial encounter
S01.00XD	Unspecified open wound of scalp, subsequent encounter
S01.00XS	Unspecified open wound of scalp, sequela
S01.01XA	Laceration without foreign body of scalp, initial encounter
S01.01XD	Laceration without foreign body of scalp, subsequent encounter
S01.01XS	Laceration without foreign body of scalp, sequela
S01.20XA	Unspecified open wound of nose, initial encounter
S01.20XD	Unspecified open wound of nose, subsequent encounter
S01.20XS	Unspecified open wound of nose, sequela
S01.21XA	Laceration without foreign body of nose, initial encounter
S01.21XD	Laceration without foreign body of nose, subsequent encounter
S01.21XS	Laceration without foreign body of nose, sequela
ICD-10 CODE	DESCRIPTION
S01.22XA	Laceration with foreign body of nose, initial encounter

ICD-10 CODE	DESCRIPTION
S01.22XD	Laceration with foreign body of nose, subsequent encounter
S01.22XS	Laceration with foreign body of nose, sequela
S01.23XA	Puncture wound without foreign body of nose, initial encounter
S01.23XD	Puncture wound without foreign body of nose, subsequent encounter
S01.23XS	Puncture wound without foreign body of nose, sequela
S01.24XA	Puncture wound with foreign body of nose, initial encounter
S01.24XD	Puncture wound with foreign body of nose, subsequent encounter
S01.24XS	Puncture wound with foreign body of nose, sequela
S01.25XA	Open bite of nose, initial encounter
S01.25XD	Open bite of nose, subsequent encounter
S01.25XS	Open bite of nose, sequela
S01.301A	Unspecified open wound of right ear, initial encounter
S01.301D	Unspecified open wound of right ear, subsequent encounter
S01.301S	Unspecified open wound of right ear, sequela
S01.302A	Unspecified open wound of left ear, initial encounter
S01.302D	Unspecified open wound of left ear, subsequent encounter
S01.302S	Unspecified open wound of left ear, sequela
S01.311A	Laceration without foreign body of right ear, initial encounter
S01.311D	Laceration without foreign body of right ear, subsequent encounter
S01.311S	Laceration without foreign body of right ear, sequela
S01.312A	Laceration without foreign body of left ear, initial encounter
S01.312D	Laceration without foreign body of left ear, subsequent encounter
S01.312S	Laceration without foreign body of left ear, sequela
S01.321A	Laceration with foreign body of right ear, initial encounter
S01.321D	Laceration with foreign body of right ear, subsequent encounter
S01.321S	Laceration with foreign body of right ear, sequela
S01.322A	Laceration with foreign body of left ear, initial encounter
S01.322D	Laceration with foreign body of left ear, subsequent encounter
S01.322S	Laceration with foreign body of left ear, sequela
S01.351A	Open bite of right ear, initial encounter
S01.351D	Open bite of right ear, subsequent encounter
S01.351S	Open bite of right ear, sequela

ICD-10 CODE	DESCRIPTION
S01.352A	Open bite of left ear, initial encounter
S01.352D	Open bite of left ear, subsequent encounter
S01.352S	Open bite of left ear, sequela
S01.411A	Laceration without foreign body of right cheek and temporomandibular area, initial encounter
S01.411D	Laceration without foreign body of right cheek and temporomandibular area, subsequent encounter
S01.411S	Laceration without foreign body of right cheek and temporomandibular area, sequela
S01.412A	Laceration without foreign body of left cheek and temporomandibular area, initial encounter
S01.412D	Laceration without foreign body of left cheek and temporomandibular area, subsequent encounter
S01.412S	Laceration without foreign body of left cheek and temporomandibular area, sequela
S01.451A	Open bite of right cheek and temporomandibular area, initial encounter
S01.451D	Open bite of right cheek and temporomandibular area, subsequent encounter
S01.451S	Open bite of right cheek and temporomandibular area, sequela
S01.452A	Open bite of left cheek and temporomandibular area, initial encounter
S01.452D	Open bite of left cheek and temporomandibular area, subsequent encounter
S01.452S	Open bite of left cheek and temporomandibular area, sequela
S01.501A	Unspecified open wound of lip, initial encounter
S01.501D	Unspecified open wound of lip, subsequent encounter
S01.501S	Unspecified open wound of lip, sequela
S01.502A	Unspecified open wound of oral cavity, initial encounter
S01.502D	Unspecified open wound of oral cavity, subsequent encounter
S01.502S	Unspecified open wound of oral cavity, sequela
S01.80XA	Unspecified open wound of other part of head, initial encounter
S01.80XD	Unspecified open wound of other part of head, subsequent encounter
S01.80XS	Unspecified open wound of other part of head, sequela
S01.81XA	Laceration without foreign body of other part of head, initial encounter
S01.81XD	Laceration without foreign body of other part of head, subsequent encounter
S01.81XS	Laceration without foreign body of other part of head, sequela
S01.82XA	Laceration with foreign body of other part of head, initial encounter

ICD-10 CODE	DESCRIPTION
S01.82XD	Laceration with foreign body of other part of head, subsequent encounter
S01.82XS	Laceration with foreign body of other part of head, sequela
S01.83XA	Puncture wound without foreign body of other part of head, initial encounter
S01.83XD	Puncture wound without foreign body of other part of head, subsequent encounter
S01.83XS	Puncture wound without foreign body of other part of head, sequela
S01.84XA	Puncture wound with foreign body of other part of head, initial encounter
S01.84XD	Puncture wound with foreign body of other part of head, subsequent encounter
S01.84XS	Puncture wound with foreign body of other part of head, sequela
S01.85XA	Open bite of other part of head, initial encounter
S01.85XD	Open bite of other part of head, subsequent encounter
S01.85XS	Open bite of other part of head, sequela
S21.001A	Unspecified open wound of right breast, initial encounter
S21.001D	Unspecified open wound of right breast, subsequent encounter
S21.001S	Unspecified open wound of right breast, sequela
S21.002A	Unspecified open wound of left breast, initial encounter
S21.002D	Unspecified open wound of left breast, subsequent encounter
S21.002S	Unspecified open wound of left breast, sequela
S21.011A	Laceration without foreign body of right breast, initial encounter
S21.011D	Laceration without foreign body of right breast, subsequent encounter
S21.011S	Laceration without foreign body of right breast, sequela
S21.012A	Laceration without foreign body of left breast, initial encounter
S21.012D	Laceration without foreign body of left breast, subsequent encounter
S21.012S	Laceration without foreign body of left breast, sequela
S21.021A	Laceration with foreign body of right breast, initial encounter
S21.021D	Laceration with foreign body of right breast, subsequent encounter
S21.021S	Laceration with foreign body of right breast, sequela
S21.022A	Laceration with foreign body of left breast, initial encounter
S21.022D	Laceration with foreign body of left breast, subsequent encounter
S21.022S	Laceration with foreign body of left breast, sequela
S21.051A	Open bite of right breast, initial encounter
S21.051D	Open bite of right breast, subsequent encounter
S21.051S	Open bite of right breast, sequela

ICD-10 CODE	DESCRIPTION
S21.052A	Open bite of left breast, initial encounter
S21.052D	Open bite of left breast, subsequent encounter
S21.052S	Open bite of left breast, sequela
S21.101A	Unspecified open wound of right front wall of thorax without penetration into thoracic cavity, initial encounter
S21.101D	Unspecified open wound of right front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.101S	Unspecified open wound of right front wall of thorax without penetration into thoracic cavity, sequela
S21.102A	Unspecified open wound of left front wall of thorax without penetration into thoracic cavity, initial encounter
ICD-10 CODE	DESCRIPTION
S21.102D	Unspecified open wound of left front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.102S	Unspecified open wound of left front wall of thorax without penetration into thoracic cavity, sequela
S21.111A	Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter
S21.111D	Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.111S	Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, sequela
S21.112A	Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter
S21.112D	Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.112S	Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, sequela
S21.121A	Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter
S21.121D	Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.121S	Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, sequela
S21.122A	Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

ICD-10 CODE	DESCRIPTION
S21.122D	Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.122S	Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, sequela
S21.151A	Open bite of right front wall of thorax without penetration into thoracic cavity, initial encounter
S21.151D	Open bite of right front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.151S	Open bite of right front wall of thorax without penetration into thoracic cavity, sequela
S21.152A	Open bite of left front wall of thorax without penetration into thoracic cavity, initial encounter
S21.152D	Open bite of left front wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.152S	Open bite of left front wall of thorax without penetration into thoracic cavity, sequela
S21.201A	Unspecified open wound of right back wall of thorax without penetration into thoracic cavity, initial encounter
S21.201D	Unspecified open wound of right back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.201S	Unspecified open wound of right back wall of thorax without penetration into thoracic cavity, sequela
S21.202A	Unspecified open wound of left back wall of thorax without penetration into thoracic cavity, initial encounter
S21.202D	Unspecified open wound of left back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.202S	Unspecified open wound of left back wall of thorax without penetration into thoracic cavity, sequela
S21.211A	Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter
S21.211D	Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.211S	Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, sequela
S21.212A	Laceration without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter
S21.212D	Laceration without foreign body of left back wall of thorax without penetration into

ICD-10 CODE	DESCRIPTION
	thoracic cavity, subsequent encounter
S21.212S	Laceration without foreign body of left back wall of thorax without penetration into thoracic cavity, sequela
S21.221A	Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter
S21.221D	Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.221S	Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, sequela
S21.222A	Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter
S21.222D	Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.222S	Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, sequela
S21.241A	Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter
S21.241D	Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.241S	Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, sequela
S21.242A	Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter
S21.242D	Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, subsequent encounter
S21.242S	Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, sequela
S31.000A	Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.000D	Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, subsequent encounter
S31.000S	Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, sequela
S31.010A	Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.010D	Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, subsequent encounter

ICD-10 CODE	DESCRIPTION
S31.010S	Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, sequela
S31.011A	Laceration without foreign body of lower back and pelvis with penetration into retroperitoneum, initial encounter
S31.011D	Laceration without foreign body of lower back and pelvis with penetration into retroperitoneum, subsequent encounter
S31.011S	Laceration without foreign body of lower back and pelvis with penetration into retroperitoneum, sequela
S31.020A	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.020D	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, subsequent encounter
S31.020S	Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, sequela
S31.050A	Open bite of lower back and pelvis without penetration into retroperitoneum, initial encounter
S31.050D	Open bite of lower back and pelvis without penetration into retroperitoneum, subsequent encounter
S31.050S	Open bite of lower back and pelvis without penetration into retroperitoneum, sequela
S31.100A	Unspecified open wound of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter
S31.100D	Unspecified open wound of abdominal wall, right upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.100S	Unspecified open wound of abdominal wall, right upper quadrant without penetration into peritoneal cavity, sequela
S31.101A	Unspecified open wound of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter
S31.101D	Unspecified open wound of abdominal wall, left upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.101S	Unspecified open wound of abdominal wall, left upper quadrant without penetration into peritoneal cavity, sequela
S31.102A	Unspecified open wound of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter
S31.102D	Unspecified open wound of abdominal wall, epigastric region without penetration into peritoneal cavity, subsequent encounter
S31.102S	Unspecified open wound of abdominal wall, epigastric region without penetration

ICD-10 CODE	DESCRIPTION
	into peritoneal cavity, sequela
S31.103A	Unspecified open wound of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter
S31.103D	Unspecified open wound of abdominal wall, right lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.103S	Unspecified open wound of abdominal wall, right lower quadrant without penetration into peritoneal cavity, sequela
S31.104A	Unspecified open wound of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter
S31.104D	Unspecified open wound of abdominal wall, left lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.104S	Unspecified open wound of abdominal wall, left lower quadrant without penetration into peritoneal cavity, sequela
S31.105A	Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter
S31.105D	Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, subsequent encounter
S31.105S	Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, sequela
S31.110A	Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter
S31.110D	Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.110S	Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, sequela
S31.111A	Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter
S31.111D	Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.111S	Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, sequela
S31.112A	Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter
S31.112D	Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, subsequent encounter
S31.112S	Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, sequela

ICD-10 CODE	DESCRIPTION
S31.113A	Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter
S31.113D	Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.113S	Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, sequela
S31.114A	Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter
S31.114D	Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.114S	Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, sequela
S31.115A	Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter
S31.115D	Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, subsequent encounter
S31.115S	Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, sequela
S31.120A	Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter
S31.120D	Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.120S	Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, sequela
S31.121A	Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter
S31.121D	Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, subsequent encounter
ICD-10 CODE	DESCRIPTION
S31.121S	Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, sequela
S31.122A	Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, initial encounter
S31.122D	Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, subsequent encounter
S31.122S	Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, sequela

ICD-10 CODE	DESCRIPTION
S31.123A	Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter
S31.123D	Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.123S	Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, sequela
S31.124A	Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter
S31.124D	Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.124S	Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, sequela
S31.125A	Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter
S31.125D	Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, subsequent encounter
S31.125S	Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, sequela
S31.129A	Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter
S31.129D	Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter
S31.129S	Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, sequela
S31.150A	Open bite of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter
S31.150D	Open bite of abdominal wall, right upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.150S	Open bite of abdominal wall, right upper quadrant without penetration into peritoneal cavity, sequela
S31.151A	Open bite of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter
S31.151D	Open bite of abdominal wall, left upper quadrant without penetration into peritoneal cavity, subsequent encounter
S31.151S	Open bite of abdominal wall, left upper quadrant without penetration into peritoneal cavity, sequela
S31.152A	Open bite of abdominal wall, epigastric region without penetration into peritoneal

ICD-10 CODE	DESCRIPTION
	cavity, initial encounter
S31.152D	Open bite of abdominal wall, epigastric region without penetration into peritoneal cavity, subsequent encounter
S31.152S	Open bite of abdominal wall, epigastric region without penetration into peritoneal cavity, sequela
S31.153A	Open bite of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter
S31.153D	Open bite of abdominal wall, right lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.153S	Open bite of abdominal wall, right lower quadrant without penetration into peritoneal cavity, sequela
S31.154A	Open bite of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter
S31.154D	Open bite of abdominal wall, left lower quadrant without penetration into peritoneal cavity, subsequent encounter
S31.154S	Open bite of abdominal wall, left lower quadrant without penetration into peritoneal cavity, sequela
S31.155A	Open bite of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter
S31.155D	Open bite of abdominal wall, periumbilic region without penetration into peritoneal cavity, subsequent encounter
S31.155S	Open bite of abdominal wall, periumbilic region without penetration into peritoneal cavity, sequela
S31.20XA	Unspecified open wound of penis, initial encounter
S31.20XD	Unspecified open wound of penis, subsequent encounter
S31.20XS	Unspecified open wound of penis, sequela
S31.21XA	Laceration without foreign body of penis, initial encounter
S31.21XD	Laceration without foreign body of penis, subsequent encounter
S31.21XS	Laceration without foreign body of penis, sequela
S31.22XA	Laceration with foreign body of penis, initial encounter
S31.22XD	Laceration with foreign body of penis, subsequent encounter
S31.22XS	Laceration with foreign body of penis, sequela
S31.25XA	Open bite of penis, initial encounter
S31.25XD	Open bite of penis, subsequent encounter
S31.25XS	Open bite of penis, sequela

ICD-10 CODE	DESCRIPTION
S31.31XA	Laceration without foreign body of scrotum and testes, initial encounter
S31.31XD	Laceration without foreign body of scrotum and testes, subsequent encounter
S31.31XS	Laceration without foreign body of scrotum and testes, sequela
S31.32XA	Laceration with foreign body of scrotum and testes, initial encounter
S31.32XD	Laceration with foreign body of scrotum and testes, subsequent encounter
S31.32XS	Laceration with foreign body of scrotum and testes, sequela
S31.35XA	Open bite of scrotum and testes, initial encounter
S31.35XD	Open bite of scrotum and testes, subsequent encounter
S31.35XS	Open bite of scrotum and testes, sequela
S31.40XA	Unspecified open wound of vagina and vulva, initial encounter
S31.40XD	Unspecified open wound of vagina and vulva, subsequent encounter
S31.40XS	Unspecified open wound of vagina and vulva, sequela
S31.41XA	Laceration without foreign body of vagina and vulva, initial encounter
S31.41XD	Laceration without foreign body of vagina and vulva, subsequent encounter
S31.41XS	Laceration without foreign body of vagina and vulva, sequela
S31.42XA	Laceration with foreign body of vagina and vulva, initial encounter
S31.42XD	Laceration with foreign body of vagina and vulva, subsequent encounter
S31.42XS	Laceration with foreign body of vagina and vulva, sequela
S31.45XA	Open bite of vagina and vulva, initial encounter
S31.45XD	Open bite of vagina and vulva, subsequent encounter
S31.45XS	Open bite of vagina and vulva, sequela
S31.811A	Laceration without foreign body of right buttock, initial encounter
S31.811D	Laceration without foreign body of right buttock, subsequent encounter
S31.811S	Laceration without foreign body of right buttock, sequela
S31.812A	Laceration with foreign body of right buttock, initial encounter
S31.812D	Laceration with foreign body of right buttock, subsequent encounter
S31.812S	Laceration with foreign body of right buttock, sequela
S31.815A	Open bite of right buttock, initial encounter
S31.815D	Open bite of right buttock, subsequent encounter
S31.815S	Open bite of right buttock, sequela
S31.819A	Unspecified open wound of right buttock, initial encounter
S31.819D	Unspecified open wound of right buttock, subsequent encounter

ICD-10 CODE	DESCRIPTION
S31.819S	Unspecified open wound of right buttock, sequela
S31.821A	Laceration without foreign body of left buttock, initial encounter
S31.821D	Laceration without foreign body of left buttock, subsequent encounter
S31.821S	Laceration without foreign body of left buttock, sequela
S31.822A	Laceration with foreign body of left buttock, initial encounter
S31.822D	Laceration with foreign body of left buttock, subsequent encounter
S31.822S	Laceration with foreign body of left buttock, sequela
S31.825A	Open bite of left buttock, initial encounter
S31.825D	Open bite of left buttock, subsequent encounter
S31.825S	Open bite of left buttock, sequela
S31.829A	Unspecified open wound of left buttock, initial encounter
S31.829D	Unspecified open wound of left buttock, subsequent encounter
S31.829S	Unspecified open wound of left buttock, sequela
S41.001A	Unspecified open wound of right shoulder, initial encounter
S41.001D	Unspecified open wound of right shoulder, subsequent encounter
S41.001S	Unspecified open wound of right shoulder, sequela
S41.002A	Unspecified open wound of left shoulder, initial encounter
S41.002D	Unspecified open wound of left shoulder, subsequent encounter
S41.002S	Unspecified open wound of left shoulder, sequela
S41.011A	Laceration without foreign body of right shoulder, initial encounter
S41.011D	Laceration without foreign body of right shoulder, subsequent encounter
S41.011S	Laceration without foreign body of right shoulder, sequela
ICD-10 CODE	DESCRIPTION
S41.012A	Laceration without foreign body of left shoulder, initial encounter
S41.012D	Laceration without foreign body of left shoulder, subsequent encounter
S41.012S	Laceration without foreign body of left shoulder, sequela
S41.021A	Laceration with foreign body of right shoulder, initial encounter
S41.021D	Laceration with foreign body of right shoulder, subsequent encounter
S41.021S	Laceration with foreign body of right shoulder, sequela
S41.022A	Laceration with foreign body of left shoulder, initial encounter
S41.022D	Laceration with foreign body of left shoulder, subsequent encounter
S41.022S	Laceration with foreign body of left shoulder, sequela

ICD-10 CODE	DESCRIPTION
S41.051A	Open bite of right shoulder, initial encounter
S41.051D	Open bite of right shoulder, subsequent encounter
S41.051S	Open bite of right shoulder, sequela
S41.052A	Open bite of left shoulder, initial encounter
S41.052D	Open bite of left shoulder, subsequent encounter
S41.052S	Open bite of left shoulder, sequela
S41.101A	Unspecified open wound of right upper arm, initial encounter
S41.101D	Unspecified open wound of right upper arm, subsequent encounter
S41.101S	Unspecified open wound of right upper arm, sequela
S41.102A	Unspecified open wound of left upper arm, initial encounter
S41.102D	Unspecified open wound of left upper arm, subsequent encounter
S41.102S	Unspecified open wound of left upper arm, sequela
S41.111A	Laceration without foreign body of right upper arm, initial encounter
S41.111D	Laceration without foreign body of right upper arm, subsequent encounter
S41.111S	Laceration without foreign body of right upper arm, sequela
S41.112A	Laceration without foreign body of left upper arm, initial encounter
S41.112D	Laceration without foreign body of left upper arm, subsequent encounter
S41.112S	Laceration without foreign body of left upper arm, sequela
S41.121A	Laceration with foreign body of right upper arm, initial encounter
S41.121D	Laceration with foreign body of right upper arm, subsequent encounter
S41.121S	Laceration with foreign body of right upper arm, sequela
S41.122A	Laceration with foreign body of left upper arm, initial encounter
S41.122D	Laceration with foreign body of left upper arm, subsequent encounter
S41.122S	Laceration with foreign body of left upper arm, sequela
S41.151A	Open bite of right upper arm, initial encounter
S41.151D	Open bite of right upper arm, subsequent encounter
S41.151S	Open bite of right upper arm, sequela
S41.152A	Open bite of left upper arm, initial encounter
S41.152D	Open bite of left upper arm, subsequent encounter
S41.152S	Open bite of left upper arm, sequela
S51.001A	Unspecified open wound of right elbow, initial encounter
S51.001D	Unspecified open wound of right elbow, subsequent encounter

ICD-10 CODE	DESCRIPTION
S51.001S	Unspecified open wound of right elbow, sequela
S51.002A	Unspecified open wound of left elbow, initial encounter
S51.002D	Unspecified open wound of left elbow, subsequent encounter
S51.002S	Unspecified open wound of left elbow, sequela
S51.011A	Laceration without foreign body of right elbow, initial encounter
S51.011D	Laceration without foreign body of right elbow, subsequent encounter
S51.011S	Laceration without foreign body of right elbow, sequela
S51.012A	Laceration without foreign body of left elbow, initial encounter
S51.012D	Laceration without foreign body of left elbow, subsequent encounter
S51.012S	Laceration without foreign body of left elbow, sequela
S51.021A	Laceration with foreign body of right elbow, initial encounter
S51.021D	Laceration with foreign body of right elbow, subsequent encounter
S51.021S	Laceration with foreign body of right elbow, sequela
S51.022A	Laceration with foreign body of left elbow, initial encounter
S51.022D	Laceration with foreign body of left elbow, subsequent encounter
S51.022S	Laceration with foreign body of left elbow, sequela
S51.051A	Open bite, right elbow, initial encounter
S51.051D	Open bite, right elbow, subsequent encounter
S51.051S	Open bite, right elbow, sequela
S51.052A	Open bite, left elbow, initial encounter
S51.052D	Open bite, left elbow, subsequent encounter
S51.052S	Open bite, left elbow, sequela
S51.801A	Unspecified open wound of right forearm, initial encounter
S51.801D	Unspecified open wound of right forearm, subsequent encounter
S51.801S	Unspecified open wound of right forearm, sequela
S51.802A	Unspecified open wound of left forearm, initial encounter
S51.802D	Unspecified open wound of left forearm, subsequent encounter
S51.802S	Unspecified open wound of left forearm, sequela
S51.811A	Laceration without foreign body of right forearm, initial encounter
S51.811D	Laceration without foreign body of right forearm, subsequent encounter
S51.811S	Laceration without foreign body of right forearm, sequela
S51.812A	Laceration without foreign body of left forearm, initial encounter

ICD-10 CODE	DESCRIPTION
S51.812D	Laceration without foreign body of left forearm, subsequent encounter
S51.812S	Laceration without foreign body of left forearm, sequela
S51.821A	Laceration with foreign body of right forearm, initial encounter
S51.821D	Laceration with foreign body of right forearm, subsequent encounter
S51.821S	Laceration with foreign body of right forearm, sequela
S51.822A	Laceration with foreign body of left forearm, initial encounter
S51.822D	Laceration with foreign body of left forearm, subsequent encounter
S51.822S	Laceration with foreign body of left forearm, sequela
S51.851A	Open bite of right forearm, initial encounter
S51.851D	Open bite of right forearm, subsequent encounter
S51.851S	Open bite of right forearm, sequela
S51.852A	Open bite of left forearm, initial encounter
S51.852D	Open bite of left forearm, subsequent encounter
S51.852S	Open bite of left forearm, sequela
S58.011A	Complete traumatic amputation at elbow level, right arm, initial encounter
S58.011D	Complete traumatic amputation at elbow level, right arm, subsequent encounter
S58.011S	Complete traumatic amputation at elbow level, right arm, sequela
S58.012A	Complete traumatic amputation at elbow level, left arm, initial encounter
S58.012D	Complete traumatic amputation at elbow level, left arm, subsequent encounter
S58.012S	Complete traumatic amputation at elbow level, left arm, sequela
S58.021A	Partial traumatic amputation at elbow level, right arm, initial encounter
S58.021D	Partial traumatic amputation at elbow level, right arm, subsequent encounter
S58.021S	Partial traumatic amputation at elbow level, right arm, sequela
S58.022A	Partial traumatic amputation at elbow level, left arm, initial encounter
S58.022D	Partial traumatic amputation at elbow level, left arm, subsequent encounter
S58.022S	Partial traumatic amputation at elbow level, left arm, sequela
S58.111A	Complete traumatic amputation at level between elbow and wrist, right arm, initial encounter
ICD-10 CODE	DESCRIPTION
S58.111D	Complete traumatic amputation at level between elbow and wrist, right arm, subsequent encounter
S58.111S	Complete traumatic amputation at level between elbow and wrist, right arm, sequela

ICD-10 CODE	DESCRIPTION
S58.112A	Complete traumatic amputation at level between elbow and wrist, left arm, initial encounter
S58.112D	Complete traumatic amputation at level between elbow and wrist, left arm, subsequent encounter
S58.112S	Complete traumatic amputation at level between elbow and wrist, left arm, sequela
S58.121A	Partial traumatic amputation at level between elbow and wrist, right arm, initial encounter
S58.121D	Partial traumatic amputation at level between elbow and wrist, right arm, subsequent encounter
S58.121S	Partial traumatic amputation at level between elbow and wrist, right arm, sequela
S58.122A	Partial traumatic amputation at level between elbow and wrist, left arm, initial encounter
S58.122D	Partial traumatic amputation at level between elbow and wrist, left arm, subsequent encounter
S58.122S	Partial traumatic amputation at level between elbow and wrist, left arm, sequela
S61.001A	Unspecified open wound of right thumb without damage to nail, initial encounter
S61.001D	Unspecified open wound of right thumb without damage to nail, subsequent encounter
S61.001S	Unspecified open wound of right thumb without damage to nail, sequela
S61.002A	Unspecified open wound of left thumb without damage to nail, initial encounter
S61.002D	Unspecified open wound of left thumb without damage to nail, subsequent encounter
S61.002S	Unspecified open wound of left thumb without damage to nail, sequela
S61.011A	Laceration without foreign body of right thumb without damage to nail, initial encounter
S61.011D	Laceration without foreign body of right thumb without damage to nail, subsequent encounter
S61.011S	Laceration without foreign body of right thumb without damage to nail, sequela
S61.012A	Laceration without foreign body of left thumb without damage to nail, initial encounter
S61.012D	Laceration without foreign body of left thumb without damage to nail, subsequent encounter
S61.012S	Laceration without foreign body of left thumb without damage to nail, sequela
S61.051A	Open bite of right thumb without damage to nail, initial encounter
S61.051D	Open bite of right thumb without damage to nail, subsequent encounter

ICD-10 CODE	DESCRIPTION
S61.051S	Open bite of right thumb without damage to nail, sequela
S61.052A	Open bite of left thumb without damage to nail, initial encounter
S61.052D	Open bite of left thumb without damage to nail, subsequent encounter
S61.052S	Open bite of left thumb without damage to nail, sequela
S61.200A	Unspecified open wound of right index finger without damage to nail, initial encounter
S61.200D	Unspecified open wound of right index finger without damage to nail, subsequent encounter
S61.200S	Unspecified open wound of right index finger without damage to nail, sequela
S61.201A	Unspecified open wound of left index finger without damage to nail, initial encounter
S61.201D	Unspecified open wound of left index finger without damage to nail, subsequent encounter
S61.201S	Unspecified open wound of left index finger without damage to nail, sequela
S61.202A	Unspecified open wound of right middle finger without damage to nail, initial encounter
S61.202D	Unspecified open wound of right middle finger without damage to nail, subsequent encounter
S61.202S	Unspecified open wound of right middle finger without damage to nail, sequela
S61.203A	Unspecified open wound of left middle finger without damage to nail, initial encounter
S61.203D	Unspecified open wound of left middle finger without damage to nail, subsequent encounter
S61.203S	Unspecified open wound of left middle finger without damage to nail, sequela
S61.204A	Unspecified open wound of right ring finger without damage to nail, initial encounter
S61.204D	Unspecified open wound of right ring finger without damage to nail, subsequent encounter
S61.204S	Unspecified open wound of right ring finger without damage to nail, sequela
S61.205A	Unspecified open wound of left ring finger without damage to nail, initial encounter
S61.205D	Unspecified open wound of left ring finger without damage to nail, subsequent encounter
S61.205S	Unspecified open wound of left ring finger without damage to nail, sequela
S61.206A	Unspecified open wound of right little finger without damage to nail, initial encounter
S61.206D	Unspecified open wound of right little finger without damage to nail, subsequent encounter

ICD-10 CODE	DESCRIPTION
S61.206S	Unspecified open wound of right little finger without damage to nail, sequela
S61.207A	Unspecified open wound of left little finger without damage to nail, initial encounter
S61.207D	Unspecified open wound of left little finger without damage to nail, subsequent encounter
S61.207S	Unspecified open wound of left little finger without damage to nail, sequela
S61.210A	Laceration without foreign body of right index finger without damage to nail, initial encounter
S61.210D	Laceration without foreign body of right index finger without damage to nail, subsequent encounter
S61.210S	Laceration without foreign body of right index finger without damage to nail, sequela
S61.211A	Laceration without foreign body of left index finger without damage to nail, initial encounter
S61.211D	Laceration without foreign body of left index finger without damage to nail, subsequent encounter
S61.211S	Laceration without foreign body of left index finger without damage to nail, sequela
S61.212A	Laceration without foreign body of right middle finger without damage to nail, initial encounter
S61.212D	Laceration without foreign body of right middle finger without damage to nail, subsequent encounter
S61.212S	Laceration without foreign body of right middle finger without damage to nail, sequela
S61.213A	Laceration without foreign body of left middle finger without damage to nail, initial encounter
S61.213D	Laceration without foreign body of left middle finger without damage to nail, subsequent encounter
S61.213S	Laceration without foreign body of left middle finger without damage to nail, sequela
S61.214A	Laceration without foreign body of right ring finger without damage to nail, initial encounter
S61.214D	Laceration without foreign body of right ring finger without damage to nail, subsequent encounter
S61.214S	Laceration without foreign body of right ring finger without damage to nail, sequela
S61.215A	Laceration without foreign body of left ring finger without damage to nail, initial encounter
S61.215D	Laceration without foreign body of left ring finger without damage to nail, subsequent encounter

ICD-10 CODE	DESCRIPTION
S61.215S	Laceration without foreign body of left ring finger without damage to nail, sequela
S61.216A	Laceration without foreign body of right little finger without damage to nail, initial encounter
S61.216D	Laceration without foreign body of right little finger without damage to nail, subsequent encounter
S61.216S	Laceration without foreign body of right little finger without damage to nail, sequela
S61.217A	Laceration without foreign body of left little finger without damage to nail, initial encounter
S61.217D	Laceration without foreign body of left little finger without damage to nail, subsequent encounter
S61.217S	Laceration without foreign body of left little finger without damage to nail, sequela
S61.220A	Laceration with foreign body of right index finger without damage to nail, initial encounter
S61.220D	Laceration with foreign body of right index finger without damage to nail, subsequent encounter
S61.220S	Laceration with foreign body of right index finger without damage to nail, sequela
S61.221A	Laceration with foreign body of left index finger without damage to nail, initial encounter
S61.221D	Laceration with foreign body of left index finger without damage to nail, subsequent encounter
S61.221S	Laceration with foreign body of left index finger without damage to nail, sequela
S61.222A	Laceration with foreign body of right middle finger without damage to nail, initial encounter
S61.222D	Laceration with foreign body of right middle finger without damage to nail, subsequent encounter
S61.222S	Laceration with foreign body of right middle finger without damage to nail, sequela
S61.223A	Laceration with foreign body of left middle finger without damage to nail, initial encounter
S61.223D	Laceration with foreign body of left middle finger without damage to nail, subsequent encounter
S61.223S	Laceration with foreign body of left middle finger without damage to nail, sequela
S61.224A	Laceration with foreign body of right ring finger without damage to nail, initial encounter
S61.224D	Laceration with foreign body of right ring finger without damage to nail, subsequent encounter
S61.224S	Laceration with foreign body of right ring finger without damage to nail, sequela

ICD-10 CODE	DESCRIPTION
S61.225A	Laceration with foreign body of left ring finger without damage to nail, initial encounter
S61.225D	Laceration with foreign body of left ring finger without damage to nail, subsequent encounter
S61.225S	Laceration with foreign body of left ring finger without damage to nail, sequela
S61.226A	Laceration with foreign body of right little finger without damage to nail, initial encounter
S61.226D	Laceration with foreign body of right little finger without damage to nail, subsequent encounter
S61.226S	Laceration with foreign body of right little finger without damage to nail, sequela
S61.227A	Laceration with foreign body of left little finger without damage to nail, initial encounter
S61.227D	Laceration with foreign body of left little finger without damage to nail, subsequent encounter
ICD-10 CODE	DESCRIPTION
S61.227S	Laceration with foreign body of left little finger without damage to nail, sequela
S61.250A	Open bite of right index finger without damage to nail, initial encounter
S61.250D	Open bite of right index finger without damage to nail, subsequent encounter
S61.250S	Open bite of right index finger without damage to nail, sequela
S61.251A	Open bite of left index finger without damage to nail, initial encounter
S61.251D	Open bite of left index finger without damage to nail, subsequent encounter
S61.251S	Open bite of left index finger without damage to nail, sequela
S61.252A	Open bite of right middle finger without damage to nail, initial encounter
S61.252D	Open bite of right middle finger without damage to nail, subsequent encounter
S61.252S	Open bite of right middle finger without damage to nail, sequela
S61.253A	Open bite of left middle finger without damage to nail, initial encounter
S61.253D	Open bite of left middle finger without damage to nail, subsequent encounter
S61.253S	Open bite of left middle finger without damage to nail, sequela
S61.254A	Open bite of right ring finger without damage to nail, initial encounter
S61.254D	Open bite of right ring finger without damage to nail, subsequent encounter
S61.254S	Open bite of right ring finger without damage to nail, sequela
S61.255A	Open bite of left ring finger without damage to nail, initial encounter
S61.255D	Open bite of left ring finger without damage to nail, subsequent encounter

ICD-10 CODE	DESCRIPTION
S61.255S	Open bite of left ring finger without damage to nail, sequela
S61.256A	Open bite of right little finger without damage to nail, initial encounter
S61.256D	Open bite of right little finger without damage to nail, subsequent encounter
S61.256S	Open bite of right little finger without damage to nail, sequela
S61.257A	Open bite of left little finger without damage to nail, initial encounter
S61.257D	Open bite of left little finger without damage to nail, subsequent encounter
S61.257S	Open bite of left little finger without damage to nail, sequela
S61.401A	Unspecified open wound of right hand, initial encounter
S61.401D	Unspecified open wound of right hand, subsequent encounter
S61.401S	Unspecified open wound of right hand, sequela
S61.402A	Unspecified open wound of left hand, initial encounter
S61.402D	Unspecified open wound of left hand, subsequent encounter
S61.402S	Unspecified open wound of left hand, sequela
S61.411A	Laceration without foreign body of right hand, initial encounter
S61.411D	Laceration without foreign body of right hand, subsequent encounter
S61.411S	Laceration without foreign body of right hand, sequela
S61.412A	Laceration without foreign body of left hand, initial encounter
S61.412D	Laceration without foreign body of left hand, subsequent encounter
S61.412S	Laceration without foreign body of left hand, sequela
S61.421A	Laceration with foreign body of right hand, initial encounter
S61.421D	Laceration with foreign body of right hand, subsequent encounter
S61.421S	Laceration with foreign body of right hand, sequela
S61.422A	Laceration with foreign body of left hand, initial encounter
S61.422D	Laceration with foreign body of left hand, subsequent encounter
S61.422S	Laceration with foreign body of left hand, sequela
S61.451A	Open bite of right hand, initial encounter
S61.451D	Open bite of right hand, subsequent encounter
S61.451S	Open bite of right hand, sequela
S61.452A	Open bite of left hand, initial encounter
S61.452D	Open bite of left hand, subsequent encounter
S61.452S	Open bite of left hand, sequela
S61.501A	Unspecified open wound of right wrist, initial encounter

ICD-10 CODE	DESCRIPTION
S61.501D	Unspecified open wound of right wrist, subsequent encounter
S61.501S	Unspecified open wound of right wrist, sequela
S61.502A	Unspecified open wound of left wrist, initial encounter
S61.502D	Unspecified open wound of left wrist, subsequent encounter
S61.502S	Unspecified open wound of left wrist, sequela
S61.511A	Laceration without foreign body of right wrist, initial encounter
S61.511D	Laceration without foreign body of right wrist, subsequent encounter
S61.511S	Laceration without foreign body of right wrist, sequela
S61.512A	Laceration without foreign body of left wrist, initial encounter
S61.512D	Laceration without foreign body of left wrist, subsequent encounter
S61.512S	Laceration without foreign body of left wrist, sequela
S61.521A	Laceration with foreign body of right wrist, initial encounter
S61.521D	Laceration with foreign body of right wrist, subsequent encounter
S61.521S	Laceration with foreign body of right wrist, sequela
S61.522A	Laceration with foreign body of left wrist, initial encounter
S61.522D	Laceration with foreign body of left wrist, subsequent encounter
S61.522S	Laceration with foreign body of left wrist, sequela
S61.551A	Open bite of right wrist, initial encounter
S61.551D	Open bite of right wrist, subsequent encounter
S61.551S	Open bite of right wrist, sequela
S61.552A	Open bite of left wrist, initial encounter
S61.552D	Open bite of left wrist, subsequent encounter
S61.552S	Open bite of left wrist, sequela
S68.011A	Complete traumatic metacarpophalangeal amputation of right thumb, initial encounter
S68.011D	Complete traumatic metacarpophalangeal amputation of right thumb, subsequent encounter
S68.011S	Complete traumatic metacarpophalangeal amputation of right thumb, sequela
S68.012A	Complete traumatic metacarpophalangeal amputation of left thumb, initial encounter
S68.012D	Complete traumatic metacarpophalangeal amputation of left thumb, subsequent encounter
S68.012S	Complete traumatic metacarpophalangeal amputation of left thumb, sequela

ICD-10 CODE	DESCRIPTION
S68.021A	Partial traumatic metacarpophalangeal amputation of right thumb, initial encounter
S68.021D	Partial traumatic metacarpophalangeal amputation of right thumb, subsequent encounter
S68.021S	Partial traumatic metacarpophalangeal amputation of right thumb, sequela
S68.022A	Partial traumatic metacarpophalangeal amputation of left thumb, initial encounter
S68.022D	Partial traumatic metacarpophalangeal amputation of left thumb, subsequent encounter
S68.022S	Partial traumatic metacarpophalangeal amputation of left thumb, sequela
S68.110A	Complete traumatic metacarpophalangeal amputation of right index finger, initial encounter
S68.110D	Complete traumatic metacarpophalangeal amputation of right index finger, subsequent encounter
S68.110S	Complete traumatic metacarpophalangeal amputation of right index finger, sequela
S68.111A	Complete traumatic metacarpophalangeal amputation of left index finger, initial encounter
S68.111D	Complete traumatic metacarpophalangeal amputation of left index finger, subsequent encounter
S68.111S	Complete traumatic metacarpophalangeal amputation of left index finger, sequela
S68.112A	Complete traumatic metacarpophalangeal amputation of right middle finger, initial encounter
S68.112D	Complete traumatic metacarpophalangeal amputation of right middle finger, subsequent encounter
S68.112S	Complete traumatic metacarpophalangeal amputation of right middle finger, sequela
S68.113A	Complete traumatic metacarpophalangeal amputation of left middle finger, initial encounter
S68.113D	Complete traumatic metacarpophalangeal amputation of left middle finger, subsequent encounter
S68.113S	Complete traumatic metacarpophalangeal amputation of left middle finger, sequela
S68.114A	Complete traumatic metacarpophalangeal amputation of right ring finger, initial encounter
S68.114D	Complete traumatic metacarpophalangeal amputation of right ring finger, subsequent encounter
S68.114S	Complete traumatic metacarpophalangeal amputation of right ring finger, sequela
ICD-10 CODE	DESCRIPTION
S68.115A	Complete traumatic metacarpophalangeal amputation of left ring finger, initial

ICD-10 CODE	DESCRIPTION
	encounter
S68.115D	Complete traumatic metacarpophalangeal amputation of left ring finger, subsequent encounter
S68.115S	Complete traumatic metacarpophalangeal amputation of left ring finger, sequela
S68.116A	Complete traumatic metacarpophalangeal amputation of right little finger, initial encounter
S68.116D	Complete traumatic metacarpophalangeal amputation of right little finger, subsequent encounter
S68.116S	Complete traumatic metacarpophalangeal amputation of right little finger, sequela
S68.117A	Complete traumatic metacarpophalangeal amputation of left little finger, initial encounter
S68.117D	Complete traumatic metacarpophalangeal amputation of left little finger, subsequent encounter
S68.117S	Complete traumatic metacarpophalangeal amputation of left little finger, sequela
S68.120A	Partial traumatic metacarpophalangeal amputation of right index finger, initial encounter
S68.120D	Partial traumatic metacarpophalangeal amputation of right index finger, subsequent encounter
S68.120S	Partial traumatic metacarpophalangeal amputation of right index finger, sequela
S68.121A	Partial traumatic metacarpophalangeal amputation of left index finger, initial encounter
S68.121D	Partial traumatic metacarpophalangeal amputation of left index finger, subsequent encounter
S68.121S	Partial traumatic metacarpophalangeal amputation of left index finger, sequela
S68.122A	Partial traumatic metacarpophalangeal amputation of right middle finger, initial encounter
S68.122D	Partial traumatic metacarpophalangeal amputation of right middle finger, subsequent encounter
S68.122S	Partial traumatic metacarpophalangeal amputation of right middle finger, sequela
S68.123A	Partial traumatic metacarpophalangeal amputation of left middle finger, initial encounter
S68.123D	Partial traumatic metacarpophalangeal amputation of left middle finger, subsequent encounter
S68.123S	Partial traumatic metacarpophalangeal amputation of left middle finger, sequela
S68.124A	Partial traumatic metacarpophalangeal amputation of right ring finger, initial encounter

ICD-10 CODE	DESCRIPTION
S68.124D	Partial traumatic metacarpophalangeal amputation of right ring finger, subsequent encounter
S68.124S	Partial traumatic metacarpophalangeal amputation of right ring finger, sequela
S68.125A	Partial traumatic metacarpophalangeal amputation of left ring finger, initial encounter
S68.125D	Partial traumatic metacarpophalangeal amputation of left ring finger, subsequent encounter
S68.125S	Partial traumatic metacarpophalangeal amputation of left ring finger, sequela
S68.126A	Partial traumatic metacarpophalangeal amputation of right little finger, initial encounter
S68.126D	Partial traumatic metacarpophalangeal amputation of right little finger, subsequent encounter
S68.126S	Partial traumatic metacarpophalangeal amputation of right little finger, sequela
S68.127A	Partial traumatic metacarpophalangeal amputation of left little finger, initial encounter
S68.127D	Partial traumatic metacarpophalangeal amputation of left little finger, subsequent encounter
S68.127S	Partial traumatic metacarpophalangeal amputation of left little finger, sequela
S71.001A	Unspecified open wound, right hip, initial encounter
S71.001D	Unspecified open wound, right hip, subsequent encounter
S71.001S	Unspecified open wound, right hip, sequela
S71.002A	Unspecified open wound, left hip, initial encounter
S71.002D	Unspecified open wound, left hip, subsequent encounter
S71.002S	Unspecified open wound, left hip, sequela
S71.011A	Laceration without foreign body, right hip, initial encounter
S71.011D	Laceration without foreign body, right hip, subsequent encounter
S71.011S	Laceration without foreign body, right hip, sequela
S71.012A	Laceration without foreign body, left hip, initial encounter
S71.012D	Laceration without foreign body, left hip, subsequent encounter
S71.012S	Laceration without foreign body, left hip, sequela
S71.021A	Laceration with foreign body, right hip, initial encounter
S71.021D	Laceration with foreign body, right hip, subsequent encounter
S71.021S	Laceration with foreign body, right hip, sequela
S71.022A	Laceration with foreign body, left hip, initial encounter

ICD-10 CODE	DESCRIPTION
S71.022D	Laceration with foreign body, left hip, subsequent encounter
S71.022S	Laceration with foreign body, left hip, sequela
S71.051A	Open bite, right hip, initial encounter
S71.051D	Open bite, right hip, subsequent encounter
S71.051S	Open bite, right hip, sequela
S71.052A	Open bite, left hip, initial encounter
S71.052D	Open bite, left hip, subsequent encounter
S71.052S	Open bite, left hip, sequela
S71.101A	Unspecified open wound, right thigh, initial encounter
S71.101D	Unspecified open wound, right thigh, subsequent encounter
S71.101S	Unspecified open wound, right thigh, sequela
S71.102A	Unspecified open wound, left thigh, initial encounter
S71.102D	Unspecified open wound, left thigh, subsequent encounter
S71.102S	Unspecified open wound, left thigh, sequela
S71.111A	Laceration without foreign body, right thigh, initial encounter
S71.111D	Laceration without foreign body, right thigh, subsequent encounter
S71.111S	Laceration without foreign body, right thigh, sequela
S71.112A	Laceration without foreign body, left thigh, initial encounter
S71.112D	Laceration without foreign body, left thigh, subsequent encounter
S71.112S	Laceration without foreign body, left thigh, sequela
S71.121A	Laceration with foreign body, right thigh, initial encounter
S71.121D	Laceration with foreign body, right thigh, subsequent encounter
S71.121S	Laceration with foreign body, right thigh, sequela
S71.122A	Laceration with foreign body, left thigh, initial encounter
S71.122D	Laceration with foreign body, left thigh, subsequent encounter
S71.122S	Laceration with foreign body, left thigh, sequela
S71.151A	Open bite, right thigh, initial encounter
S71.151D	Open bite, right thigh, subsequent encounter
S71.151S	Open bite, right thigh, sequela
S71.152A	Open bite, left thigh, initial encounter
S71.152D	Open bite, left thigh, subsequent encounter
S71.152S	Open bite, left thigh, sequela

ICD-10 CODE	DESCRIPTION
S81.001A	Unspecified open wound, right knee, initial encounter
S81.001D	Unspecified open wound, right knee, subsequent encounter
S81.001S	Unspecified open wound, right knee, sequela
S81.002A	Unspecified open wound, left knee, initial encounter
S81.002D	Unspecified open wound, left knee, subsequent encounter
S81.002S	Unspecified open wound, left knee, sequela
S81.011A	Laceration without foreign body, right knee, initial encounter
S81.011D	Laceration without foreign body, right knee, subsequent encounter
S81.011S	Laceration without foreign body, right knee, sequela
S81.012A	Laceration without foreign body, left knee, initial encounter
S81.012D	Laceration without foreign body, left knee, subsequent encounter
S81.012S	Laceration without foreign body, left knee, sequela
S81.021A	Laceration with foreign body, right knee, initial encounter
S81.021D	Laceration with foreign body, right knee, subsequent encounter
S81.021S	Laceration with foreign body, right knee, sequela
S81.022A	Laceration with foreign body, left knee, initial encounter
S81.022D	Laceration with foreign body, left knee, subsequent encounter
S81.022S	Laceration with foreign body, left knee, sequela
S81.031A	Puncture wound without foreign body, right knee, initial encounter
ICD-10 CODE	DESCRIPTION
S81.031D	Puncture wound without foreign body, right knee, subsequent encounter
S81.031S	Puncture wound without foreign body, right knee, sequela
S81.032A	Puncture wound without foreign body, left knee, initial encounter
S81.032D	Puncture wound without foreign body, left knee, subsequent encounter
S81.032S	Puncture wound without foreign body, left knee, sequela
S81.041A	Puncture wound with foreign body, right knee, initial encounter
S81.041D	Puncture wound with foreign body, right knee, subsequent encounter
S81.041S	Puncture wound with foreign body, right knee, sequela
S81.042A	Puncture wound with foreign body, left knee, initial encounter
S81.042D	Puncture wound with foreign body, left knee, subsequent encounter
S81.042S	Puncture wound with foreign body, left knee, sequela
S81.051A	Open bite, right knee, initial encounter

ICD-10 CODE	DESCRIPTION
S81.051D	Open bite, right knee, subsequent encounter
S81.051S	Open bite, right knee, sequela
S81.052A	Open bite, left knee, initial encounter
S81.052D	Open bite, left knee, subsequent encounter
S81.052S	Open bite, left knee, sequela
S81.801A	Unspecified open wound, right lower leg, initial encounter
S81.801D	Unspecified open wound, right lower leg, subsequent encounter
S81.801S	Unspecified open wound, right lower leg, sequela
S81.802A	Unspecified open wound, left lower leg, initial encounter
S81.802D	Unspecified open wound, left lower leg, subsequent encounter
S81.802S	Unspecified open wound, left lower leg, sequela
S81.811A	Laceration without foreign body, right lower leg, initial encounter
S81.811D	Laceration without foreign body, right lower leg, subsequent encounter
S81.811S	Laceration without foreign body, right lower leg, sequela
S81.812A	Laceration without foreign body, left lower leg, initial encounter
S81.812D	Laceration without foreign body, left lower leg, subsequent encounter
S81.812S	Laceration without foreign body, left lower leg, sequela
S81.821A	Laceration with foreign body, right lower leg, initial encounter
S81.821D	Laceration with foreign body, right lower leg, subsequent encounter
S81.821S	Laceration with foreign body, right lower leg, sequela
S81.822A	Laceration with foreign body, left lower leg, initial encounter
S81.822D	Laceration with foreign body, left lower leg, subsequent encounter
S81.822S	Laceration with foreign body, left lower leg, sequela
S81.831A	Puncture wound without foreign body, right lower leg, initial encounter
S81.831D	Puncture wound without foreign body, right lower leg, subsequent encounter
S81.831S	Puncture wound without foreign body, right lower leg, sequela
S81.832A	Puncture wound without foreign body, left lower leg, initial encounter
S81.832D	Puncture wound without foreign body, left lower leg, subsequent encounter
S81.832S	Puncture wound without foreign body, left lower leg, sequela
S81.841A	Puncture wound with foreign body, right lower leg, initial encounter
S81.841D	Puncture wound with foreign body, right lower leg, subsequent encounter
S81.841S	Puncture wound with foreign body, right lower leg, sequela

ICD-10 CODE	DESCRIPTION
S81.842A	Puncture wound with foreign body, left lower leg, initial encounter
S81.842D	Puncture wound with foreign body, left lower leg, subsequent encounter
S81.842S	Puncture wound with foreign body, left lower leg, sequela
S81.851A	Open bite, right lower leg, initial encounter
S81.851D	Open bite, right lower leg, subsequent encounter
S81.851S	Open bite, right lower leg, sequela
S81.852A	Open bite, left lower leg, initial encounter
S81.852D	Open bite, left lower leg, subsequent encounter
S81.852S	Open bite, left lower leg, sequela
S91.001A	Unspecified open wound, right ankle, initial encounter
S91.001D	Unspecified open wound, right ankle, subsequent encounter
S91.001S	Unspecified open wound, right ankle, sequela
S91.002A	Unspecified open wound, left ankle, initial encounter
S91.002D	Unspecified open wound, left ankle, subsequent encounter
S91.002S	Unspecified open wound, left ankle, sequela
S91.011A	Laceration without foreign body, right ankle, initial encounter
S91.011D	Laceration without foreign body, right ankle, subsequent encounter
S91.011S	Laceration without foreign body, right ankle, sequela
S91.012A	Laceration without foreign body, left ankle, initial encounter
S91.012D	Laceration without foreign body, left ankle, subsequent encounter
S91.012S	Laceration without foreign body, left ankle, sequela
S91.021A	Laceration with foreign body, right ankle, initial encounter
S91.021D	Laceration with foreign body, right ankle, subsequent encounter
S91.021S	Laceration with foreign body, right ankle, sequela
S91.022A	Laceration with foreign body, left ankle, initial encounter
S91.022D	Laceration with foreign body, left ankle, subsequent encounter
S91.022S	Laceration with foreign body, left ankle, sequela
S91.051A	Open bite, right ankle, initial encounter
S91.051D	Open bite, right ankle, subsequent encounter
S91.051S	Open bite, right ankle, sequela
S91.052A	Open bite, left ankle, initial encounter
S91.052D	Open bite, left ankle, subsequent encounter

ICD-10 CODE	DESCRIPTION
S91.052S	Open bite, left ankle, sequela
S91.101A	Unspecified open wound of right great toe without damage to nail, initial encounter
S91.101D	Unspecified open wound of right great toe without damage to nail, subsequent encounter
S91.101S	Unspecified open wound of right great toe without damage to nail, sequela
S91.102A	Unspecified open wound of left great toe without damage to nail, initial encounter
S91.102D	Unspecified open wound of left great toe without damage to nail, subsequent encounter
S91.102S	Unspecified open wound of left great toe without damage to nail, sequela
S91.104A	Unspecified open wound of right lesser toe(s) without damage to nail, initial encounter
S91.104D	Unspecified open wound of right lesser toe(s) without damage to nail, subsequent encounter
S91.104S	Unspecified open wound of right lesser toe(s) without damage to nail, sequela
S91.105A	Unspecified open wound of left lesser toe(s) without damage to nail, initial encounter
S91.105D	Unspecified open wound of left lesser toe(s) without damage to nail, subsequent encounter
S91.105S	Unspecified open wound of left lesser toe(s) without damage to nail, sequela
S91.111A	Laceration without foreign body of right great toe without damage to nail, initial encounter
S91.111D	Laceration without foreign body of right great toe without damage to nail, subsequent encounter
S91.111S	Laceration without foreign body of right great toe without damage to nail, sequela
S91.112A	Laceration without foreign body of left great toe without damage to nail, initial encounter
S91.112D	Laceration without foreign body of left great toe without damage to nail, subsequent encounter
S91.112S	Laceration without foreign body of left great toe without damage to nail, sequela
S91.114A	Laceration without foreign body of right lesser toe(s) without damage to nail, initial encounter
S91.114D	Laceration without foreign body of right lesser toe(s) without damage to nail, subsequent encounter
S91.114S	Laceration without foreign body of right lesser toe(s) without damage to nail, sequela

ICD-10 CODE	DESCRIPTION
S91.115A	Laceration without foreign body of left lesser toe(s) without damage to nail, initial encounter
S91.115D	Laceration without foreign body of left lesser toe(s) without damage to nail, subsequent encounter
ICD-10 CODE	DESCRIPTION
S91.115S	Laceration without foreign body of left lesser toe(s) without damage to nail, sequela
S91.121A	Laceration with foreign body of right great toe without damage to nail, initial encounter
S91.121D	Laceration with foreign body of right great toe without damage to nail, subsequent encounter
S91.121S	Laceration with foreign body of right great toe without damage to nail, sequela
S91.122A	Laceration with foreign body of left great toe without damage to nail, initial encounter
S91.122D	Laceration with foreign body of left great toe without damage to nail, subsequent encounter
S91.122S	Laceration with foreign body of left great toe without damage to nail, sequela
S91.124A	Laceration with foreign body of right lesser toe(s) without damage to nail, initial encounter
S91.124D	Laceration with foreign body of right lesser toe(s) without damage to nail, subsequent encounter
S91.124S	Laceration with foreign body of right lesser toe(s) without damage to nail, sequela
S91.125A	Laceration with foreign body of left lesser toe(s) without damage to nail, initial encounter
S91.125D	Laceration with foreign body of left lesser toe(s) without damage to nail, subsequent encounter
S91.125S	Laceration with foreign body of left lesser toe(s) without damage to nail, sequela
S91.151A	Open bite of right great toe without damage to nail, initial encounter
S91.151D	Open bite of right great toe without damage to nail, subsequent encounter
S91.151S	Open bite of right great toe without damage to nail, sequela
S91.152A	Open bite of left great toe without damage to nail, initial encounter
S91.152D	Open bite of left great toe without damage to nail, subsequent encounter
S91.152S	Open bite of left great toe without damage to nail, sequela
S91.154A	Open bite of right lesser toe(s) without damage to nail, initial encounter
S91.154D	Open bite of right lesser toe(s) without damage to nail, subsequent encounter
S91.154S	Open bite of right lesser toe(s) without damage to nail, sequela

ICD-10 CODE	DESCRIPTION
S91.301A	Unspecified open wound, right foot, initial encounter
S91.301D	Unspecified open wound, right foot, subsequent encounter
S91.301S	Unspecified open wound, right foot, sequela
S91.302A	Unspecified open wound, left foot, initial encounter
S91.302D	Unspecified open wound, left foot, subsequent encounter
S91.302S	Unspecified open wound, left foot, sequela
S91.311A	Laceration without foreign body, right foot, initial encounter
S91.311D	Laceration without foreign body, right foot, subsequent encounter
S91.311S	Laceration without foreign body, right foot, sequela
S91.312A	Laceration without foreign body, left foot, initial encounter
S91.312D	Laceration without foreign body, left foot, subsequent encounter
S91.312S	Laceration without foreign body, left foot, sequela
S91.321A	Laceration with foreign body, right foot, initial encounter
S91.321D	Laceration with foreign body, right foot, subsequent encounter
S91.321S	Laceration with foreign body, right foot, sequela
S91.322A	Laceration with foreign body, left foot, initial encounter
S91.322D	Laceration with foreign body, left foot, subsequent encounter
S91.322S	Laceration with foreign body, left foot, sequela
S91.351A	Open bite, right foot, initial encounter
S91.351D	Open bite, right foot, subsequent encounter
S91.351S	Open bite, right foot, sequela
S91.352A	Open bite, left foot, initial encounter
S91.352D	Open bite, left foot, subsequent encounter
S91.352S	Open bite, left foot, sequela
T31.33	Burns involving 30-39% of body surface with 30-39% third degree burns
T81.31XA	Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
T81.31XD	Disruption of external operation (surgical) wound, not elsewhere classified, subsequent encounter
T81.31XS	Disruption of external operation (surgical) wound, not elsewhere classified, sequela
T81.32XA	Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter
T81.32XD	Disruption of internal operation (surgical) wound, not elsewhere classified,

ICD-10 CODE	DESCRIPTION
	subsequent encounter
T81.32XS	Disruption of internal operation (surgical) wound, not elsewhere classified, sequela
T81.89XA	Other complications of procedures, not elsewhere classified, initial encounter
T81.89XD	Other complications of procedures, not elsewhere classified, subsequent encounter
T81.89XS	Other complications of procedures, not elsewhere classified, sequela
T87.41	Infection of amputation stump, right upper extremity
T87.42	Infection of amputation stump, left upper extremity
T87.43	Infection of amputation stump, right lower extremity
T87.44	Infection of amputation stump, left lower extremity
T87.51	Necrosis of amputation stump, right upper extremity
T87.52	Necrosis of amputation stump, left upper extremity
T87.53	Necrosis of amputation stump, right lower extremity
T87.54	Necrosis of amputation stump, left lower extremity

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:

*For ICD-10-CM codes E10.620, E10.621, E10.622, E10.628, E10.65, E10.69, E11.620, E11.621, E11.622, E11.628, E11.65, E11.69, the "specified manifestation" is skin ulcer. For clarity one should consider adding a 2nd ICD-10 code (L97.1XX - L98.4XX ICD-10 codes asterisked above) to define the ulcer.

*For ICD-10-CM code I96 - When a traumatic injury leads to appreciable amounts of devitalized or contaminated tissue that requires extensive debridement, a reasonable (but not ideal) diagnosis is "traumatic gangrene," defined by Dorland's as "gangrene that occurs as a consequence of accidental injury." "Gangrene" means "devitalized tissue," not necessarily "contaminated." ICD-10-CM code I96 should be used when billing for this "extensive debridement."

Group 2 Paragraph:

For CPT codes 11055-11057, the claim must have at least <u>one</u> of the following nineteen diagnosis codes and at least <u>one</u> of the following diagnosis codes either L03.311, L03.312, L03.313, L03.314, L03.315, L03.316 or M79.671, M79.672, M79.674, M79.675.

Group 2 Codes:

ICD-10 CODE	DESCRIPTION
E10.621*	Type 1 diabetes mellitus with foot ulcer
E11.621*	Type 2 diabetes mellitus with foot ulcer
E75.21*	Fabry (-Anderson) disease
G60.0*	Hereditary motor and sensory neuropathy
G60.1*	Refsum's disease

ICD-10 CODE	DESCRIPTION
G60.2*	Neuropathy in association with hereditary ataxia
G60.3*	Idiopathic progressive neuropathy
G60.8*	Other hereditary and idiopathic neuropathies
L11.0*	Acquired keratosis follicularis
L84*	Corns and callosities
L85.0*	Acquired ichthyosis
L85.1*	Acquired keratosis [keratoderma] palmaris et plantaris
L85.2*	Keratosis punctata (palmaris et plantaris)
L85.8*	Other specified epidermal thickening
L86*	Keratoderma in diseases classified elsewhere
L87.0*	Keratosis follicularis et parafollicularis in cutem penetrans
L87.2*	Elastosis perforans serpiginosa
Q81.9*	Epidermolysis bullosa, unspecified
Q82.8*	Other specified congenital malformations of skin

Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation:

* The claim must have at least one of the following nineteen diagnosis codes: E10.621, E11.621 E75.21, G60.0, G60.1, G60.2, G60.3, G60.8, L11.0, L84, L85.0, L85.1, L85.2, L85.8, L86, L87.0, L87.2, or Q81.9, Q82.8 and one of the following ten diagnosis codes: L03.311, L03.312, L03.313, L03.314, L03.315, L03.316 or M79.671, M79.672, M79.674, M79.675.

* Use ICD-10-CM code Q81.9, Q82.8 only for those hyperkeratotic, symptomatic lesions referable to this diagnosis such as painful porokeratosis or keratoderma.

Group 3 Paragraph:

For CPT codes 11055-11057, the claim must have at least <u>one</u> of the following nineteen diagnosis codes (E10.621, E11.621, E75.21, G60.0, G60.1, G60.2, G60.3, G60.8, L11.0, L84, L85.0, L85.1, L85.2, L85.8, L86, L87.0, L87.2 or Q81.9, Q82.8) <u>and</u> at least <u>one</u> of the following diagnosis codes:

Group 3 Codes:

ICD-10 CODE	DESCRIPTION
L03.311	Cellulitis of abdominal wall
L03.312	Cellulitis of back [any part except buttock]
L03.313	Cellulitis of chest wall
L03.314	Cellulitis of groin
L03.315	Cellulitis of perineum

ICD-10 CODE	DESCRIPTION
L03.316	Cellulitis of umbilicus
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)

Group 3 Medical Necessity ICD-10 Codes Asterisk Explanation:

The claim must have at least one of the following nineteen diagnosis codes: E10.621, E11.621, E75.21, G60.0, G60.1, G60.2, G60.3, G60.8, L11.0, L84, L85.0, L85.1, L85.2, L85.8. L86, L87.0. L87.2, or Q81.9, Q82.8 **and** one of the following ten diagnosis codes: L03.311, L03.312, L03.313, L03.314, L03.315, L03.316 or M79.671, M79.672, M79.674, M79.675.

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All ICD-10 codes that are **not** listed in the ICD-10 Codes That Support Medical Necessity section of this policy.

Group 1 Codes:

N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
999x	Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

CODE	DESCRIPTION
99999	Not Applicable

Other Coding Information

N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)

LCD(s)
L34243 - Treatment of Ulcers & Symptomatic Hyperkeratoses

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

Updated on 10/04/2019 with effective dates 10/01/2019 - N/A

Keywords

- Treatment
- ulcer
- symptomatic
- hyperkeratosis
- 11042
- 11043
- 11044
- 11045

- 11046
- 11047
- 11055
- 11056
- 11057
- 97597
- 97598