2025 Procedural Payment Guide

TendoNova®

TendoNova®

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Disclaimers

1. Coding Information Disclaimer:

Please note: This coding information may include codes for procedures for which TendoNova™ currently offers no cleared or approved products. These codes are provided solely for informational purposes to offer comprehensive coding information and are not intended to promote the use of any TendoNova™ products for unapproved indications. The Health Care Provider (HCP) is solely responsible for selecting appropriate treatment modalities and sites of service based on the patient's medical needs and the independent medical judgment of the provider.

2. Legal and Regulatory Disclaimer:

The information in this guide is gathered from third-party sources and may change without notice due to frequently evolving laws, regulations, and payer policies. This guide is for illustrative purposes only and does not constitute reimbursement or legal advice. TendoNova™ encourages providers to submit accurate and appropriate claims for services rendered. It is the provider's responsibility to determine medical necessity, select the appropriate site of service, and ensure the correct coding, charges, and modifiers are applied.

3. Medicare and Coverage Disclaimer:

Providers must comply with Medicare's National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and any other relevant payer requirements, which may be subject to frequent updates. TendoNova™ recommends consulting with payers, reimbursement specialists, or legal counsel for guidance on coding, coverage, and reimbursement matters. TendoNova™ does not promote the use of its products outside of their FDA-approved indications.

4. Responsibility for Coding and Reimbursement:

The coding, reimbursement information, and examples provided in this guide are for informational purposes only and do not constitute formal coding guidance or legal advice. The determination of coding accuracy, medical necessity, and coverage are solely the responsibility of the HCP. Coverage and reimbursement decisions are made by third-party payers and are not under TendoNova™'s control. TendoNova™ specifically disclaims any responsibility for such coverage and reimbursement determinations.

Coding Reference for Tenotomy and Fasciotomy Procedures*

The TendoNova Ocelot™ Nano is a microinvasive technology that uses a powered stainless steel cutting tip that can be used by a physician to perform percutaneous tenotomy. **It is not a standalone procedure but rather a tool used to perform existing procedures, aligning with standard CPT codes already in use today**. *It is indicated for the fragmentation and debridement of soft tissue. Fragmentation and debridement help to disrupt scar tissue associated with tendinopathy. This allows the diseased tendon to restart the healing process and heal properly. The Ocelot Nano is less expensive and less invasive than alternative products/procedures and can be performed in an ambulatory surgical center, hospital, or physician office.*

Tenotomy and Fasciotomy Medicare Physician, Hospital Outpatient, and ASC Payments						2025 Medicare National Average Payments			
APC GROUP	CPT CODE	CPT CODE DESCRIPTION	RVU			PHYSICIAN		FACILITY	
			Work	Total Facility	Total Office	In-Faculty	In-Office	Hospital	ASC
Elbow									
5113	24357	Tenotomy, elbow, lateral or medial (e.g., epicondylitis, tennis elbow, golfer's elbow); percutaneous	5.44	12.74	12.74	$ 412.00	$ 412.00	$ 3,245.00	$ 1,579.00
Femur & Knee									
5113	27306	Tenotomy, percutaneous, single tendon (separate procedure)	4.74	10.58	10.58	$ 342.00	$ 342.00	$ 3,245.00	$ 1,579.00
5113	27307	Tenotomy, percutaneous, multiple tendons	6.06	12.62	12.62	$ 408.00	$ 408.00	$ 3,245.00	$ 1,579.00
Shoulder									
5114	23405	Tenotomy, shoulder area, single tendon	8.54	18.81	18.81	$ 608.00	$ 608.00	$ 7,144.00	$ 3,511.00
Plantar Fascia									
5113	28008	Fasciotomy, foot and/or toe (percutaneous or open)	4.59	9.00	12.80	$ 291.00	$ 414.00	$ 3,245.00	$ 1,579.00
Achilles									
5112	27605	Tenotomy, percutaneous, Achilles tendon (separate procedure)	2.92	5.57	9.79	$ 180.00	$ 317.00	$ 1,600.00	$ 838.00
Hip									
5112	27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	5.74	11.92	11.92	$ 396.00	$ 396.00	$ 1,600.00	$ 838.00
	27005	Tenotomy, hip flexor	10.70	22.14	22.14	$ 716.00	$ 716.00		N/A
5113	27006	Tenotomy, abductor and/or extensor of hip	10.11	21.84	21.84	$ 706.00	$ 706.00	$ 3,245.00	$ 1,579.00
Ultrasound		***Physician Only***							
5522	76881	Ultrasound, extremity, nonvascular, real-time with image documentation	0.90	1.60	1.60	$ 52.00	$ 52.00	$ 106.00	$ 10.00
	76882	Ultrasound, extremity, nonvascular, real-time with image documentation	0.69	1.93	1.93	$ 62.00	$ 62.00		
	76942	Ultrasound, guidance for needle placement (e.g. biopsy, aspiration, injection, localization device)	0.67	1.77	1.77	$ 57.00	$ 57.00		
Supply Code		***Generally, NOT separately payable unless agreed upon by a specific third-party payer***							
	99070	Supplies & materials provided by the physician over and above, usually involved in an office visit.							
	A4649	Miscellaneous supplies in a surgical setting.							
Unlisted									
	20999	Unlisted procedure, musculoskeletal system, general							

Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia.

**This information is provided for informational purposes only and represents no statement, promise, or guarantee by TendoNova concerning levels of reimbursement, payment, or charge, or that reimbursement will be made. It is not intended to increase or maximize reimbursement by any payer and Providers assume full responsibility for reimbursement decisions or actions. TendoNova strongly recommends consulting with third-party payers for local coverage and payment amounts. The coding options listed in this guide are not intended to be all-inclusive nor a recommendation for coding. Providers should review payer policies for coverage, payment and coding guidelines.*

Contact sales@tendonova.com for additional information | tendonova.com

Closure Definition

Wound closures using adhesive strips or tape alone or not separately reportable. In the absence of operative procedure, these types of wound closures are included in the E&M services. Under limited circumstances, wound closure uses tissue adhesive may be reported separately.

Closure Techniques

The standard methods for wound closure are sutures, staples, and adhesives.
https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-3.pdf

Place of Service Code Set

- **11 In Office (non-facility fee applies)**

  Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

- **22 Hospital Outpatient department (facility fee applies)**

  A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)

- **24 Ambulatory Surgical Center ASC (facility fee applies)**

  A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

CMS Requirements for Ambulatory surgical center or ASC *– Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in Subpart B and C of this part.*

Source:
https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_l_ambulatory.pdf

Section §416.2 Definitions

Possible Denial Errors

- CPT code is not allowed at the site of service or on the provider's/group's fee schedule
- Provider Taxonomy code associated with the National Provider Identifier does not allow for the procedure to be performed

Billing FAQs

Q: Can I charge the self pay/cash fee for PRP after billing a patient's insurance for the TendoNova tenotomy?

- Self pay rate would apply if the patient's insurance benefit does not cover the procedure or the provider is out of network with the insurance carrier.
- If the patient is not using insurance the provider must provide a good faith estimate of expected charges.

Q: Can I charge self pay instead of insurance for office procedures?

- Self pay rate would apply if the patient's insurance benefit does not cover the procedure or the provider is out of network with the insurance carrier.
- If the patient is not using insurance the provider must provide a good faith estimate of expected charges.

Advance Beneficiary Notice of Non-coverage (ABN)

The Advance Beneficiary Notice of Non-coverage (ABN), Form (CMS-R-131) helps Medicare Fee-for-Service (FFS) patients make informed decisions about items and services Medicare usually covers but may not in specific situations. For example, the items or services may not be medically necessary for a patient.
https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-6.pdf

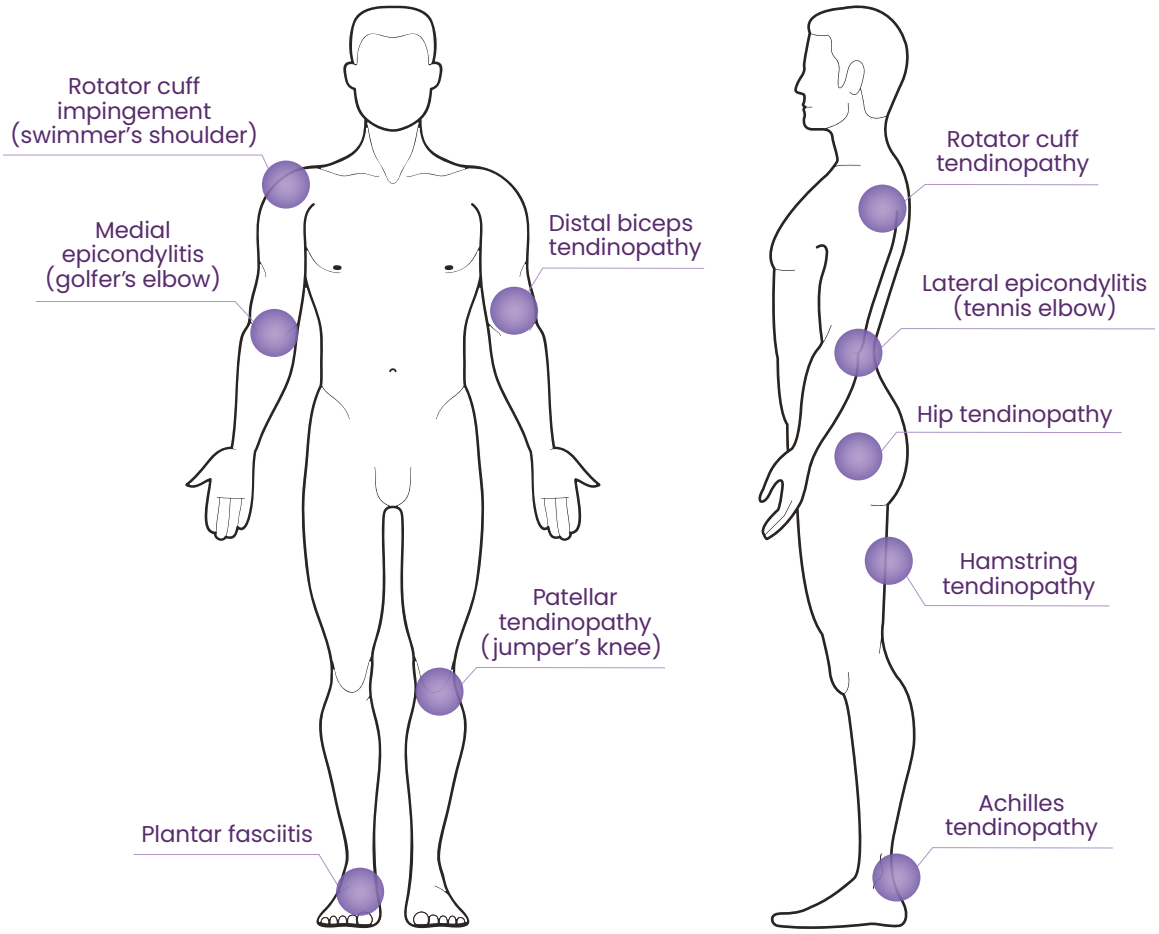
Unlisted Procedure Coding in CPT®

Current Procedural Terminology® (CPT) includes thousands of codes that cover a wide range of medical procedures. However, it is recognized that some services or procedures performed by physicians or other qualified healthcare professionals may not be captured by a specific code within the CPT code set. To address this, **unlisted procedure codes** have been designated to report services or procedures that do not have a sufficiently specific code.

Unlisted codes serve as a temporary means for reporting and tracking procedures until a more specific, established code is available. For example, this may apply to a procedure like **Percutaneous Tenotomy** (which may not yet have a designated CPT Category I code).

Unlisted procedure codes are typically used when no specific Category I code exists for the service provided. These codes generally end with the **digits 99** and can be found at the end of each section in the CPT code set.

The use of unlisted codes allows healthcare providers to submit claims for procedures that lack a specific code, ensuring that these services can still be reported and tracked for billing, reimbursement, and statistical purposes. However, it's important to note that the use of unlisted codes may require additional documentation and a clear description of the procedure in order to justify the claim to payers.



Pre-Determination Request for Percutaneous Tenotomy

What is a Pre-determination Request?

A pre-determination request is a written request submitted to the payer asking for coverage approval of a specific procedure—percutaneous tenotomy—for a future date. It is important to note that a pre-determination request does not guarantee coverage or payment but serves as an official request for approval prior to the procedure.

Why is Pre-determination Necessary?

Pre-determination is essential for protecting both the patient and the provider from potential non-payment or delayed reimbursement. It also helps demonstrate the demand for the procedure, which can strengthen the case for approval. Many insurers require pre-determination for certain procedures, including percutaneous tenotomy. Despite being reported under an unlisted code, percutaneous tenotomy has been approved and reimbursed by multiple payers, making pre-determination a prudent step to take.

What Should Be Included in Your Pre-determination Request?

When submitting a pre-determination request for percutaneous tenotomy, ensure the following information is included:

1. **Patient Diagnosis and Justification for Procedure:**

Provide detailed information about the patient's diagnosis and clearly explain why the percutaneous tenotomy procedure is medically necessary for this patient. Be specific about the patient's condition and how this procedure is the appropriate course of action.

2. **Patient History and Supporting Medical Documentation:**

Include relevant patient history, diagnostic studies, lab results, and any pertinent prior treatments or medications. This documentation should support the medical necessity of the procedure and demonstrate that all other treatment options have been considered or exhausted.

3. **Clinical and Procedural Experience:**

Describe your clinical experience and procedural familiarity with percutaneous tenotomy. Include any relevant details about your past cases, outcomes, and proficiency in performing the procedure.

4. **Supporting Clinical Literature and Studies:**

Provide relevant clinical studies, articles, or research that demonstrate the safety and efficacy of percutaneous tenotomy. Including evidence from reputable sources can bolster your request by showing that the procedure is widely accepted and proven to be effective in treating conditions like the one being presented.

Some examples of clinical literature to include might be studies or reviews that highlight:

- The success rates of percutaneous tenotomy for the targeted condition
- Long-term outcomes for patients undergoing the procedure
- Comparative studies to demonstrate the advantages of percutaneous tenotomy over other treatment options

Do's and Don'ts Peer to Peer Review for Percutaneous Tenotomy

DO:

1. **Provide a Brief Description of Your Background and Credentials:**
   - **Introduce yourself:** Include a brief summary of your background, including your specialty and relevant credentials.
   - **Request the Payor's Medical Director Credentials:** Ask for a statement outlining the background and credentials of the Medical Director representing the payer.
   - **Request a Specialty-Specific Peer Review:** If possible, request to speak with a Medical Director who has expertise in the same or a similar specialty. Keep in mind that the payer may or may not grant this request.

Do's and Don'ts (cont.)

DO:

2. **State "Individual Consideration" for This Patient:**
   - Clearly request "Individual Consideration" for this patient, emphasizing that this request pertains to their unique medical needs and is not a generic case.
3. **Provide Specific Details About the Patient's Need for Percutaneous Tenotomy:**
   - Explain in detail why the percutaneous tenotomy procedure is necessary to address the patient's specific conditions or problems.
   - Provide clear rationale for why this procedure is the best option for treatment.
4. **Provide Detailed Patient History and Significant Findings:**
   - Include a thorough medical history of the patient, highlighting significant findings and clinical details that justify the use of percutaneous tenotomy.
3. **Provide Your Experience with the Procedure:**
   - State the number of times you have performed the percutaneous tenotomy procedure, emphasizing your clinical experience and proficiency.
6. **Include Anecdotal Patient Response (if applicable):**
   - Share general and anecdotal feedback from patients who have undergone the procedure, including any positive outcomes or improvements in their condition.
   - If the procedure is not approved, explain the alternative treatment options, potential complications, expected length of stay, and cost of those alternatives.
7. **Document the Patient's Informed Decision:**
   - State that you and the patient have discussed all available treatment options, and that both you and the patient agreed that percutaneous tenotomy offers the best opportunity for clinical improvement.
8. **Provide Relevant Clinical Publications:**
   - Attach or reference available clinical publications related to the safety, efficacy, and outcomes of percutaneous tenotomy to support your request.

DON'T:

1. **Comment on the Insurance Company's Formal Policies or Procedures:**
   - Avoid referencing the payers' formal policies and procedures. Focus solely on individual consideration for this specific patient's case.
2. **Discuss Payment Levels or Amounts at This Stage:**
   - Do not mention or inquire about payment levels or reimbursement amounts at this point in the process. This request should focus on medical necessity and justification for the procedure.

Additional Notes:

- *It is not uncommon for the first Peer-to-Peer review to be with a physician who may not have expertise in the specific field related to the procedure.*
- *If you feel a more specialized review is needed, you may request a review by a physician with a similar specialty. However, keep in mind that the payer may or may not grant this request.*

Sample Pre-Determination Letter

[*Date*]

[*Name Payer Contact*]

[*Name of Health Insurance Company*]

[*Address*]

[*City, State, ZIP Code*]

RE: Coverage for percutaneous tenotomy

Patient: [*Patient Name*]

Date of Birth: [*Date*]

Diagnosis: [*Diagnosis*], [*ICD-10-CM*]

Group/Policy Number: [*Number*]

Policyholder: [*Policyholder Name*]

Dear [*Payer Contact Name*]:

I am writing on behalf of my patient, [*Patient Name]*, to document the medical necessity to treat their [*Diagnosis*] with percutaneous tenotomy.

This letter serves to document my patient's medical history and diagnosis and to summarize my treatment rationale. Please refer to the [*List any Enclosures*] enclosed with this letter.

Summary of Patient's Medical History and Diagnosis

[*Patient Name*] is [*Age*] years old and was initially diagnosed with [*Diagnosis*] [*ICD-10-CM*] on [*Date*]. [*Patient Name*] has been in my care since [*Date*].

[*Provide a discussion of the patient's clinical history, current symptoms and condition, any potential contraindications, any relevant laboratory test results, and diagnostic ultrasound, highlighting the factors leading you to recommend use of the product*]

Rationale for Treatment

[*Include your clinical rationale and reasons for prescribing the product*]

In summary, [*percutaneous tenotomy using a mechanical cutter*] is medically necessary and reasonable to treat [*Patient Name's*] [*Diagnosis*], and I ask you to please consider coverage of percutaneous tenotomy on [*Patient Name's*] behalf. Please refer to the enclosed supporting documents for further details, and do not hesitate to call me at [*Phone Number*] if you have any questions or if you require additional information.

Thank you for your attention to this matter.

Sincerely,

[*Physician Name and Credentials*]

[*NPI Number*]

Enclosures: [*List any Enclosures, Procedure rational, Operative report, Bibliography and Medical Records*]

SAMPLE 1

Operative Report (ASC + Anesthesia)

Assessment/Plan

Preoperative Diagnosis:

1. Right chronic lateral epicondylitis M 77.11

Postoperative Diagnosis: Same

Procedure:

1. Right lateral epicondyle percutaneous debridement with mechanical cutting tool using real time ultrasound to left elbow CPT 24357, CPT 76882
2. Platelet rich plasma (PRP) injection to right lateral epicondyle CPT 0232T

Surgeon:

Assistant: None
Anesthesia: Local
Tourniquet time: Not used
Blood loss: Minimal
Drains: None

Complications: None
Specimens: None
Implants: None
Explants: None

Indications for Procedure:

This is a pleasant patient who was found to have right chronic lateral epicondylitis recalcitrant to conservative treatment. The patient wished to undergo percutaneous mechanical cutting debridement of his right lateral epicondylitis with PRP injection after discussing the risks, benefits, and alternatives.

The patient understood the risks, benefits, and alternatives of the procedure and consented to undergo it. The risks include but are not limited to: injury to his surrounding structures including motor or sensory loss, neuroma formation, infection, pain or stiffness, tendon rupture, symptom recurrence and need for additional surgery.

Description of Procedure:

The patient was seen in the preoperative unit and the right upper extremity was marked appropriately. I harvested 10 mL of blood from his antecubital vein and placed it into a PRP tube. I then spun it down for 12 minutes to extract the PRP. I was able to harvest 5 mL of sterile PRP. I then prepared the PRP in a syringe in preparation for surgical injection. I sterilely prepped the right lateral elbow with alcohol and performed a block to the skin overlying the right lateral epicondyle using 5 mL of 1% lidocaine. He tolerated the block without complication.

The patient was then taken back to the operating suite and placed in the supine position where a timeout was performed indicating the proper patient, with the procedure, and the proper extremity. The orthopedic staff, nursing staff, and anesthesia staff were in agreement. Preoperative IV antibiotics were not given as this was a minimally invasive, percutaneous procedure.

The patient's right upper extremity was then prepped and draped in the usual sterile fashion over a nonsterile tourniquet. I confirmed that the patient was properly anesthetized. I then used an ultrasound to identify the lateral epicondyle and the origin of the ECRB on the lateral epicondyle. Then made a small stab incision with 11 blade.

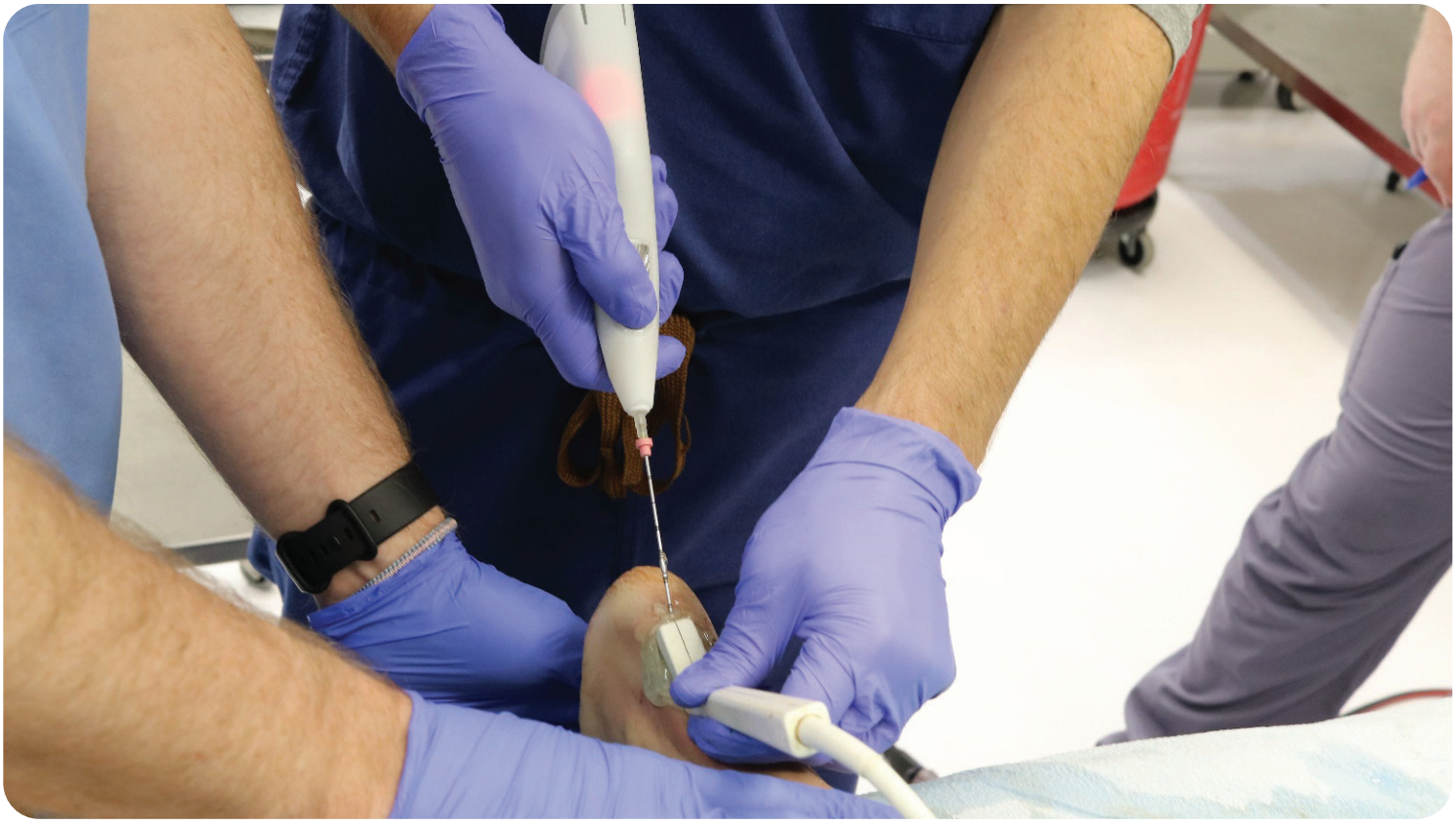
I then passed the mechanical cutting tool to the deep origin of the extensor carpi radialis brevis (ECRB) tendon on the lateral epicondyle. There were large amounts of denuded ECRB tissue as well as an osteophyte on the lateral epicondyle. Using the mechanical cutting tool, I was then able to debride through denuded ECRB tissue at its origin on the lateral epicondyle with the help of real-time ultrasound placed on the lateral epicondyle.

I was able to free up and excise all of the denuded, chronic tissue at the ECRB origin as well as the osteophyte consistent with his chronic lateral epicondylitis using ultrasound in real-time. I was very happy with the result. I was able to free up all of the chronic, denuded tissue at the ECRB origin while leaving the healthy tissue intact. I then sterilely prepped the PRP that was previously harvested in preop for surgical injection. I then removed the needle and injected 5 mL of platelet rich plasma into the ECRB at its origin on the lateral epicondyle.

He tolerated the injection without complication. I closed the stab incision with Dermabond. I scrubbed in, and performed the entire procedure myself.

Disposition:

The patient was awoken and transferred to PACU in stable condition. The patient will be allowed to remove the dressing tomorrow. I will see the patient back in 2 weeks for repeat evaluation and wound check.



SAMPLE 2

Office + PRP

Percutaneous, targeted tenotomy and soft tissue debridement

Current Medications:

lisinopril, 10mg, QD
rosuvastatin, 20mg, QD
methocarbamol, 500mg, QD
ibuprofen, 800mg, BID
Celebrex, 200mg, BID

Diagnosis:

M25.571 - PAIN IN RIGHT ANKLE AND JOINTS OF RIGHT FOOT
S76.311A - STRAIN MSL/FASC/TND OIST GRP AT THI LEV, RIGHT THIGH, INIT
M65.871 - OTHER SYNOVITIS AND TENOSYNOVITIS, RIGHT ANKLE AND FOOT
S86.311A - STRAIN MUSC/TEND PERONEAL GRP AT LOW LEG LEV, R LEG, INIT
M67.971 - UNSPECIFIED DISORDER OF SYNOVIUM AND TENDON, RIGHT ANKLE AND FOOT
M76.61 - ACHILLES TENDINITIS, RIGHT LEG

SAMPLE 2 (continued)

Treatment Side:
Right

Treatment Site:
Peroneus Brevis and Achilles

Post treatment Injection Type:
Platelet-rich Plasma

Guidance Type:
None

Informed Consent and Time-Out Procedure:
The patient and I (MD) discussed the patient's condition and potential benefits of the percutaneous tenotomy and soft tissue debridement. The risks associated, likely, and worst outcomes were discussed as well. This included a question-and-answer session. The patient acknowledged understanding of the treatment and the risks and benefits associated with it. This constituted informed consent.

Time-out was performed with the patient, me (MD), and the assistants in the procedure room. We all verbalized the correct treatment site and identity of the patient.

Procedure:
The target site was identified, and sterile prep and drape performed. Betadine was used on the skin unless allergic. A field block or regional block with 0.5% Marcaine was performed. The Clarius HD3 ultrasound was used where indicated to localize the soft tissue target. A new, sterile stainless steel cutting device was percutaneously inserted in a safe zone and delivered to the target, confirmed by ultrasound, radiograph, or clinical means.
Debridement was then performed using the motorized franseen needle, again directly visualized by the ultrasound when indicated. The debridement was continued until the tendinosis was fully addressed or until the desired percentage of tendon transection occurred.

Once the debridement and partial tenotomy was accomplished, the delivery needle was disconnected from the internal franseen needle, irrigation was performed, and when prescribed platelet-rich plasma was inserted. If platelet-rich plasma was prescribed, both needles were removed. A sterile bandage was applied.

Patient Instructions:
The patient will be instructed to avoid anti-inflammatory medications and vitamins for the immediate post-procedure time-frame. A warm compress, heating pad, or warm soak is recommended to help stimulate blood flow over the next several days. There are no new physical restrictions added. The patient is told to call our office number 24 hrs a day / 7 days a week for any concerns. Any emergent concerns should prompt the patient to call 911 or report to the closest emergency department.

SAMPLE 2 (continued)

Disposition and Follow-Up:

The patient tolerated the procedure well. Was monitored for several minutes after, and helped to stand under supervision to be sure they were stable. They will be discharged with the instructions listed above, and a follow-up is scheduled to assess effectiveness.

Attestation:

I was personally present and responsible for this procedure. I personally performed the procedure myself.

ICD 10 Codes:

M25.571 - PAIN IN RIGHT ANKLE AND JOINTS OF RIGHT FOOT
S76.311A - STRAIN MSL/FASC/TND OIST GRP AT THI LEV, RIGHT THIGH, INIT
M65.871 - OTHER SYNOVITIS AND TENOSYNOVITIS, RIGHT ANKLE AND FOOT
S86.311A - STRAIN MUSC/TEND PERONEAL GRP AT LOW LEG LEV, R LEG, INIT
M67.971 - UNSPECIFIED DISORDER OF SYNOVIUM AND TENDON, RIGHT ANKLE AND FOOT
M76.61 - ACHILLES TENDINITIS, RIGHT LEG

SAMPLE 3

HOPD

Patient Indications:
Patient presented with a <duration of symptoms> history of <nature of patient's symptoms> symptomology.

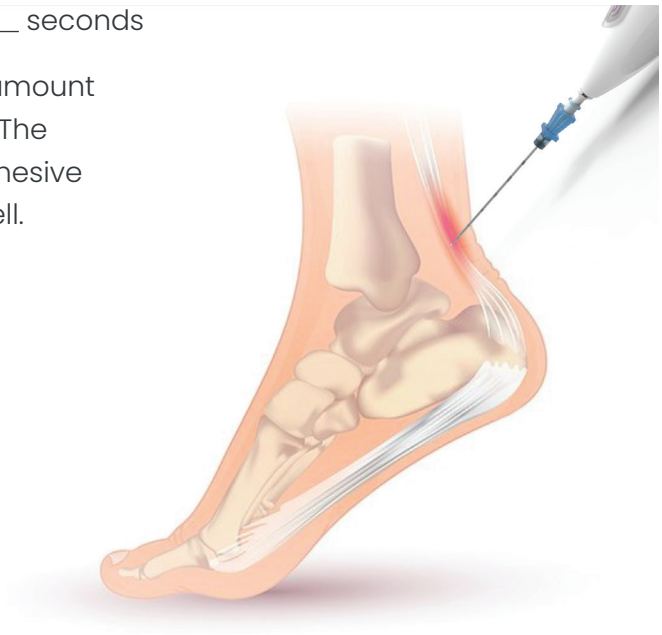
Procedure Performed:
Percutaneous tenotomy of <tendon (example: common extensor tendon)> under ultrasound guidance to cut tendon.

Description of Procedure:
A sterile sleeve was placed over the ultrasound transducer. The anatomy was identified, and the diseased tissue was visualized. The area was prepped with an antimicrobial solution, draped and the area was injected a local anesthetic. A skin wheal was placed and the involved tissue was anesthetized with fast-acting local anesthetic.

The diseased <tendon name> tendon, was examined along its length under ultrasound imaging. The surgical instrument was introduced and advanced to the diseased tendon. Once the tip of the instrument reached the pathologic tissue, the tendon was debrided.
Total cut time was _____ minutes and _____ seconds

Upon completion of the procedure, the minimal amount of bleeding was controlled by applying pressure. The area was covered with a cotton swab and an adhesive bandage. The patient tolerated the procedure well.

Detailed post-procedure instructions and a return appointment were given. The patient was advised <adjunctive measures recommended (example: sling, PT)> and to return to clinic at <time period>.



References

Modifier 52 Refence
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r442cp.pdf

Diagnosis Codes (ICD-10):

Rotator Cuff / Shoulder Tendons

- M75.100 – Unspecified rotator cuff tear or rupture of unspecified shoulder
- M75.101 - Unspecified rotator cuff tear or rupture or right shoulder, not specified as traumatic
- M75.102 - Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
- M75.40 - Impingement syndrome of unspecified shoulder
- M75.41 - Impingement syndrome of right shoulder
- M75.42 - Impingement syndrome of left shoulder

Biceps Tendonitis

- M75.20–M75.22 – Bicipital tendinitis (unspecified, right, left)

Lateral Epicondylitis (Tennis Elbow)

- M77.10 – Unspecified elbow
- M77.11 – Right elbow
- M77.12 – Left elbow

Medial Epicondylitis (Golfer's Elbow)

- M77.00 – Unspecified elbow
- M77.01 – Right elbow
- M77.02 – Left elbow

Achilles Tendonitis

- M76.60 – Achilles tendonitis, unspecified leg
- M76.61 – Achilles tendonitis, right leg
- M76.62 – Achilles tendonitis, left leg

Patellar Tendonitis (Jumper's Knee)

- M76.50 – Patellar tendonitis, unspecified knee
- M76.51 – Patellar tendonitis, right knee
- M76.52 – Patellar tendonitis, left knee

Gluteal Tendonitis

- M76.00 – Gluteal tendonitis, unspecified side
- M76.01 – Gluteal tendonitis, right side
- M76.02 – Gluteal tendonitis, left side

Plantar Fasciitis

- M72.2 – Plantar fasciitis

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