

## **Example: New Patient with Plantar Fasciitis That Receives an Injection and a Significant & Separately Identifiable Evaluation and Management Service.**

Claim form includes submission of:

- CPT® 99204 – Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.<sup>1</sup>
- CPT® 20550 – Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")<sup>1</sup>
- HCPCS code for steroid product

Submission of these codes requires the performance and documentation of the injection procedure and an evaluation and management that is significant in nature and separately identifiable from the procedure. Chapter I, Section D of the National Correct Coding Initiative Policy Manual for Medicare Services states an evaluation and management submitted at the same time as a procedure may be related to the same diagnosis necessitating performance of the procedure, but cannot include any work inherent in the procedure, supervision of others performing the procedure, or time for interpreting the result of the procedure.<sup>2</sup>

In the example progress note below, the “evaluation” of the evaluation and management service is documented **in blue**. The “management” of the evaluation and management service is documented **in red**. The procedure is documented **in green**.

### **Chief Complaint:**

Right heel pain

### **History of Present Illness:**

Patient is complaining of deep, sore achy pain at the plantar medial aspect of their right heel. This has been present while getting better and worse over the period of many years, but the pain has been getting worse over the last 6-12 months and during this time the pain has been more consistent. As this illness has been present for over one year and the symptoms are progressing, this is a “chronic illness with progression.” The onset of this problem was gradual and the patient cannot recall any related injury / trauma. The pain is worse first thing in the morning and when getting up after an extended period of rest. The patient states first steps getting out of a car after a long car ride is an example of when the pain is worse. Typically, but not always, once they get walking for a couple minutes in an example such as this one, the pain is not as bad. The pain is typically worse in unsupportive shoes and not as bad when wearing supportive shoes, such as athletic sneakers.

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Patient has attempted ice, changing shoes, and over-the-counter anti-inflammatory medication for this and none of these have provided any considerable relief.

**Exam:**

Examination of the right plantar fascia at its origin on the plantar medial calcaneal tubercle reveals pain with palpation. No point tenderness, no ecchymosis, no heat, no edema, and no redness in this area. No defects or fibromas felt on palpation of the right plantar fascia. Examination along the proximal aspect of the medial band of the right plantar fascia reveals pain with palpation. No point tenderness or ecchymosis there. Medial to lateral compression of the right reveals no pain. Dorsiflexion range of motion of the right ankle is normal. There is flattening of the medial longitudinal arch of the right foot when standing in relaxed calcaneal stance position. On gait analysis, there appears to be some guarding of this painful area of the right heel through stance phase.

**Assessment:**

Plantar fasciitis right

M72.2 - Plantar fasciitis

M79.671 - Pain in right foot

**Medical Management**

This is plantar fasciitis. I explained plantar fasciitis to this patient. I explained the potential risks and complications associated with this diagnosis including difficulty walking, impact on activities, stress fracture, and more. I explained potential etiologies, including foot structure, foot function, unsupportive shoes, and others. In this patient, it seems the plantar fasciitis is a result of flexible pes planus coupled with insufficient support of the medial longitudinal arch leading to strain on the plantar fascia. I explained flexible pes planus to the patient and the role it plays in plantar fasciitis. I outlined steps that can be taken to try to prevent recurrence, and this included a discussion of shoe gear, shoe inserts, and the possibility of rigid, custom, functional orthotics. I explained how these can help with this issue. I reviewed stretching exercises with the patient and provided a handout that details these stretching exercises. I also advised icing and described a proper icing regimen. We discussed other treatment options including over-the-counter oral anti-inflammatory, topical anti-inflammatory, prescription oral anti-inflammatory drugs, therapeutic ultrasound, shoe gear change, physical therapy, and others. I explained potential advantages and disadvantages of each of these options. We also discussed potential risks and benefits associated with each of each of these treatment options. The patient asked me about any activity restrictions associated with plantar fasciitis and I answered that question. The patient also asked me for shoe recommendations which I provided. After discussing the option of prescription oral anti-inflammatory medication, and associated potential risks and benefits, we decided to not pursue this. This was a form of prescription drug management.

This evaluation and management described above was significant in nature and separately identifiable from the procedure described below with no overlap in the work that was required to provide the above evaluation and management with the work required to perform the below described procedure.

## **Procedure**

We also discussed the possibility of a steroid injection. I explained what would be involved with a steroid injection to the area of inflammation within the plantar fascia. I explained the potential advantages and disadvantages of this injection. I explained the potential risks and complications associated with this injection, including hypopigmentation, rupture of the structure(s) exposed to the steroid, fat pad atrophy, increase in pain, infection, nerve damage, increased in blood sugar, and allergic reaction.

The patient wanted to try a steroid injection. The patient was in the seated position in the exam chair. The injection site was cleansed with betadine. Ethyl chloride was applied to the injection site. An injection consisting of \_\_\_\_ cc of \_\_\_\_\_ was performed. The contents were infiltrated into the area of inflammation of the plantar fascia. Pressure was applied to the site to achieve hemostasis. A dry bandage was applied. I explained what to expect after this injection and asked the patient to let us know if anything other than these expectations occur. Activity instructions were provided.