Use of Compression System in Patients with Venous Ulcers

Coding Specifications

Codes required to document patient has venous ulcer and a visit occurred:

A line item ICD-9-CM diagnosis code for chronic venous hypertension and an ICD-9-CM diagnosis code for chronic ulcer and a CPT E/M service code are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

Chronic venous hypertension line item ICD-9-CM diagnosis codes

- 459.31, 459.33, 459.81 (chronic venous hypertension)

AND

Chronic ulcer line item ICD-9-CM diagnosis codes

- 707.12, 707.13, 707.14, 707.15, 707.19 (chronic ulcer of lower limbs)

AND

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office —established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***CPT II 4267F:*** Compression therapy prescribed
- ***CPT II 4267F–1P:*** Documentation of medical reason(s) for not prescribing compression therapy (eg, severe arterial occlusive disease)
- ***CPT II 4267F–2P:*** Documentation of patient reason(s) for not prescribing compression therapy
- ***CPT II 4267F–3P:*** Documentation of system reason(s) for not prescribing compression therapy
- ***CPT II 4267F–8P:*** Compression therapy not prescribed, reason not otherwise specified