Clinical Practice Guideline: **Unna Boot**

Date of Implementation: **February 18, 2016**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT® Code 29580 - Unna boot bandage - to be medically necessary when used for a primary diagnosis from the table below with the following indications:

- To treat venous vascular insufficiency;
- For the treatment of ulcers with and without inflammation of the lower extremities which are caused by increased venous pressure, venous insufficiency, or capillary dysfunction; and
- For the management of sprains, strains, dislocations, and minor fractures (initial care only).

Unna boot application is *not* indicated for use with ulcers resulting from arterial disease or diabetes.

Other considerations:

A. This code is to be used for management of sprains, strains, dislocations, and minor fractures requiring immobilization as part of the treatment plan. Although an Unna boot is frequently used to help with reduction of lower extremity edema, it is considered a part of the dressing and should not be billed separately in wound debridement.
B. An Unna boot, as well as other dressings such as Kling, Profore, etc., may be used as a dressing as an adjunct to wound debridement and will be covered as a supply; however, should not be billed with CPT® 29580.
C. The method of application (primary or secondary dressing) will be left to the discretion of the provider.
D. An Unna Boot is considered to be a compression dressing, not a cast. Therefore, the supply for Unna boot is included in the payment of the procedure and not paid separately.

CPT® codes and descriptions applicable when medically necessary per the criteria listed above

CPT® Code	CPT® Code Description
29580	Strapping; Unna boot

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Unna Boot
Revised – Draft
To CQT for review 03/10/2025
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ICD-10 codes and descriptions applicable when medically necessary per the criteria listed above

ICD-10 Code	ICD-10 Code Description
Information listed in brackets below has been added for clarification purposes	
I80.00 – I80.299	Phlebitis and thrombophlebitis of superficial vessels of unspecified lower extremity - Phlebitis and thrombophlebitis of other deep vessels of unspecified lower extremity
I83.002 – I83.009, I83.012 – I83.019, I83.022 – I83.029, I83.10 – I83.12, I83.202 – I83.209, I83.212 – I83.219, I83.222 – I83.229, I83.811 – I83.899	Varicose veins of lower extremities
I87.011 – I87.099	Postthrombotic syndrome of lower extremity
I87.2	Venous insufficiency (chronic) (peripheral)
I87.311 – I87.319	Chronic venous hypertension (idiopathic) with ulcer of lower extremity
I87.331 – I87.339	Chronic venous hypertension (idiopathic) with ulcer and inflammation of lower extremity
L89.500 – L89.629, L89.90 – L89.95	Pressure ulcer of lower extremity
L97.201 – L97.929, L98.491 – L98.499	Non-pressure chronic ulcer of lower extremity
M25.471 – M25.476	Effusion, ankle and foot
M66.271 – M66.279, M66.28 – M66.29, M66.361 – M66.379, M66.38 – M66.39	Spontaneous rupture of tendons, ankle and foot
M84.361A – M84.379S	Stress fracture, lower extremity
R60.0 – R60.9	Localized, generalized, or unspecified edema
S81.801A – S81.859S, S86.021A – S86.929S, S91.001A – S91.359S, S96.021A – S96.899S	Open wound of lower extremity

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ICD-10 Code	ICD-10 Code Description
S82.301A – S82.309S, S82.391A – S82.399S, S82.51XA – S82.66XS, S82.841A – S82.856S, S82.871A – S82.899S, S89.101A – S89.199S, S89.301A – S89.399S	Fracture of tibia and fibula
S86.011A – S86.019S, S93.401A – S93.699S, S96.011A – S96.0119S, S96.111A – S96.119S, S96.211A – S96.219S,	Strains and sprains of ankle and foot
S90.00XA – S90.32XS	Contusion of foot and ankle
S92.001A – S92.356S, S92.401A – S92.599S, S92.901A – S92.919S	Fracture of talus, calcaneus, metatarsal, foot, and toe(s)
S93.101A – S93.106S	Subluxation or dislocation of toe(s)
S93.111A – S93.139S, S93.311A – S93.326S	Subluxation or dislocation of interphalangeal, tarsal, and tarsometatarsal joint of foot
S93.301A – S93.306S, 393.331A – 393.336S, S93.01XA – S93.06XS	Subluxation or dislocation of foot and ankle
S96.811A – S96.819S, S96.911A – S96.919S	Strain of other specified, unspecified muscle and tendons of foot and ankle
T81.89XA – T81.89XS	Other complications of procedures, not elsewhere classified [i.e., non-healing surgical wound]

BACKGROUND

Unna Boots are named after a German dermatologist, Paul Gerson Unna. The Unna Boot is a commercially prepared, medically impregnated compression support dressing, usually made of cotton, which has a zinc oxide paste applied uniformly to the entire bandage. The zinc oxide paste in the Unna Boot helps ease skin irritation and keeps the area moist. The zinc promotes healing within wound sites, making it useful for burns and ulcers. Zinc oxide paste is superior to gelatins used in other dressings because it does not harden or cake. Calamine lotion or glycerin may also be used. The bandage is applied to the leg from the toe to the knee by overlapping wraps of impregnated gauze. The Unna boot forms a semi-rigid soft cast which should be left in place for 4 to 7 days. The Unna boot bandage restricts the volume of the leg, controls edema, and encourages more normal prograde venous blood

flow with reduction in the subcutaneous blood pressure. The net effect is improved healing of venous stasis ulcers of the lower extremities. Impregnated gauze wraps are commonly referred to as a "soft cast" that are used to deliver sustained, graduated compression for the management of lower extremity edema and ulcerations associated with venous insufficiency. Unna Boots provide between 20-30 mmHg in pressure, making them useful in a variety of wounds. It supports vascular problems, helps with healing leg ulcers, swelling or lymphedema by giving compression to the areas that are wrapped. In general, Unna Boots are used to treat wounds with light to moderate drainage and sometimes used with hydrogel dressings. Unna Boots are more commonly used for patients who are active and can move on their own, as opposed to patients who are confined to a wheelchair or bed.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner’s scope of practice, training, and experience, a member’s condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

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