BCA’s 15 Minute Coding Pearl
Drill Down - Coding Non-displaced Fractures

Considered Global Surgery Coding Versus Itemized Service Coding

A PDF copy of these slides is available for printing

Recorded September 2016
Actual Recording Time 17 Minutes
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CPT “Fracture Care Codes”
From CPT’s Musculoskeletal Section - 20000 Code Range

Over the years, BCA has entertained many questions regarding CPT fracture care codes. CPT codes are written to identify a fracture treatment as:

(a) open treatment (open surgical procedures)
(b) closed treatment with manipulation (reduction), and/or
(c) closed treatment without manipulation

All these codes represent “major surgery” because all include 90 days of follow-up.

Today’s lesson focuses specifically on the coding dilemma when assigning service codes for care of non-displaced fractures which do not require manipulation (reduction), nor do they require open repair (ORIF).
Brown Consulting Associates, Inc.

Bonnie R. Hoag, RN, CCS-P, is the founder and a principal owner of Brown Consulting Associates, Inc., (BCA) which was established in 1989. Bonnie has served as a national physician office consultant and seminar speaker for a variety of firms, including St. Anthony Publishing and Consulting in Alexandria, Virginia and Medical Learning Inc. in Minneapolis, Minnesota. Bonnie presents multiple seminars each year to groups such as Montana Medical Association, Idaho Medical Association, Iowa Medical Society, and National Association of Community Health Centers.

Since 1990 she and other BCA consultants have provided unique training to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) throughout the U.S. Nearly 50 percent of BCA’s clinic client-base is FQHC facilities. She has provided FQHC/RHC seminars for HRSA, National Health Service Corp, National Association of Community Health Centers, and various Regional Primary Care Associations. Bonnie is honored to serve on the board of directors at a large community health center in her community. With her guidance, Brown Consulting Associates, Inc. has developed and presents live, web-based certification training.

As a senior consultant Bonnie’s work on the BCA auditing team involves E/M and procedure coding and documentation audits. This includes onsite and live web-based training with clinicians where their medical records are used during training with a goal to improve the quality of the medical records and coding compliance. She has a special interest in Chronic Care Management projects and new Behavioral Health Consultant (BHC) services. Bonnie and other BCA consultants serve as a coding instructor for BCA’s six-month, live web-based CCEP program, which is designed for coders and billers who wish to become certified.

Historically, Bonnie spent twelve years as director and instructor for the coding program at the College of Southern Idaho. She has served on the AHIMA National Physician Practice Council Group. In the “early days” of state-based managed care, Bonnie worked with the State of Idaho Department of Health as a “Physician Representative.”

On occasion Bonnie is called upon to work with health care legal defense attorneys to assist physicians in resolving third-party-payer coding actions. Bonnie has provided physician/clinician training and coder/biller training in nearly one hundred different health centers nationwide.

Sixteen years of clinical experience combined with twenty-six years of coding consulting and training provides an exceptional skill base for application to the challenging and changing medical coding environment.

Bonnie graduated from Los Angeles County-USC Medical Center School of Nursing in 1973. Her nursing experience includes office and hospital nursing in the areas of surgery, ER, ICU, and home health. She served as an Air Force Flight Nurse.

Bonnie worked in physician office nursing and management, dealing directly with reimbursement issues in Las Vegas, Nevada; Salt Lake City, Utah; and Twin Falls, Idaho. She has been teaching and consulting since 1988 and has worked in 41 states. As a physician reimbursement consultant, Bonnie visits physician offices, clinics and ERs to assess the issues that directly and indirectly affect reimbursement and CMS compliance.
Shawn R. Hafer, CCS-P, CPC, is a senior consultant and co-owner of Brown Consulting. She has enjoyed more than 20 years of physician coding and reimbursement experience in a variety of specialties. She holds coding certifications from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) and is a member of both organizations. Her background provides an excellent foundation for the demanding medical coding environment.

Shawn has been with Brown Consulting since 1999, and is uniquely qualified due to her diverse management skills, experience, and coding and billing expertise. Shawn also serves as a senior auditor conducting hundreds of medical record audits each year providing both clinician and coder training in all facets of coding and documentation.

Shawn's creative skills and experience have lead to the development of many coding tools and published training material used by Brown Consulting clients and Brown Consulting students. Shawn developed Brown’s popular New Doctor Training Program. She also developed the Brown Girls Favorite ICD-10-CM Diagnosis Code Booklet. Shawn spends much of her training time at clinic locations ranging from small rural health clinics served only by visiting providers to large inner-city clinics with more than 100 clinicians.

Shawn is the architect of our long-standing Brown Consulting Webinar Program offering both clinician and coder webinars and classes. Our fee-based webinars typically involve two-hour training sessions paired with post-training assessments; most are certified with CEUs. Topics include E/M Coding, Level I-III; Diagnosis Coding, (14 separate sessions) including Beginning and Intermediate Diagnosis Coding, as well as ICD-10-CM chapter-based webinars; Preventive Service Webinars; FQHC Specific Webinars; Use of Modifiers I & II; Minor Surgery Coding; Coding from an Op Report; Behavioral Health for Non-prescribers; Behavioral Health/Psychiatry for Prescribers. We also offer various specialty-based webinars and FQHC-specific webinars. Shawn is also responsible for the Brown Consulting Chart Auditing Training Series, which includes six sessions.

Historically, Shawn has worked with healthcare defense attorneys on behalf of physicians involved in third-party payer audits. Shawn authors and presents coding seminars and webinars for our many workshop/seminar partners including the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, West Virginia Primary Care Association and other regional and national groups.

For ten years, Shawn served as a coding instructor at the College of Southern Idaho and for Northwest Regional Primary Care Association, and was a long-term member of the Advisory Committee for Coding Education at the College of Southern Idaho. Shawn attended the College of Southern Idaho in Twin Falls, ID and Pima College in Tucson, AZ.

Meri Harrington, CPC, CEMC, brings with her 12 years of coding and auditing experience with a multispecialty rural health clinic that led the way in the rural residency training program. She was responsible for writing the E&M coding policy for the organization, as well as conducting multiple clinician and peer audits and education sessions. She has also assisted with internal audits to assure Meaningful Use implementation and attestations.

Meri and the BCA team perform documentation quality and coding compliance audits and customized clinician and coder training. She has spent multiple hours working alongside clinicians and peers on projects aimed at improving the user-friendliness of electronic medical record programs.

Meri has a special interest in data analysis and training related to the intricacies of appropriate ICD-10-CM diagnosis codes and chronic care coding with expertise related to HCCs. She has had the
opportunity to work along side third-party payers with a focus on appropriate diagnosis coding as a risk-based measurement instrument.

Meri’s knowledge and study of contemporary “quality” healthcare concerns coupled with her understanding of MACRA, MIPs and other emerging quality-based federal reimbursement plans, has positioned Meri to guide BCA in such a manner that we are able to incorporate emerging physician documentation requirements in current coding and documentation training.

For several years, Meri has served as the director of BCA’s six-month Comprehensive Coding Education Program which is designed to prepare coders and billers for professional national certification.

Meri also enjoys unique auditing and training services with clinics that provide focused services such as Contraceptive Management /Family Planning, and HIV services. Meri spends a great deal of her time working with Family Practice, Pediatrics, Geriatrics and OB-GYN. She is an expert with surgical operative report code extraction.

Historically, Meri’s education includes several years volunteering as an EMT in her local community. Meri attended the Community Colleges of Spokane – Colville IEL. Meri has developed multiple educational programs including the BCA Transition Mission training series, which was extensively utilized by clinics throughout the US as a tool for ICD-10-CM Implementation.

**Ginger Avery, CPC, CPMA,** joined the Brown Consulting team with 20 years of experience in medical coding and billing. She began her career performing home health billing for a rural county hospital. While working for an ASC her administrative skills lead to a significantly improved revenue cycle process. After obtaining her coding certification in 2005, she worked for the medical practice division of a large hospital, and while she specialized in cardiology, she also worked closely with hospitalists and family practice clinicians. She performed internal audits and provider education, and worked closely with projects aimed at improving the use of electronic medical record programs.

Ginger enjoys clinician medical record auditing and clinician and coder training. Ginger is extensively involved in a major third-party HCC project. Because of her coding expertise and her interest in CMS and state regulation she monitors BCA’s Coding Question Program. Ginger has extensive experience with data extraction from multiple EMR/EHR products, making her Brown Consulting’s ‘go to EMR advisor.’ Ginger has taken the lead in our new 15-Minute Coding Pearl Series. She plans to make these brief, topic-focused, on-demand recording available to clients on our codinghelp.com website in October 2016.

Historically, Ginger served as a member of the compliance committee and was responsible for writing policies and procedures related to billing, coding and auditing. Ginger obtained her Certified Professional Medical Auditor (CPMA) credential in 2014. Ginger has served the coder-community in many ways with her most recent duty as past President of her local American Academy of Professional Coders (AAPC) chapter.
Holly E. Gault, BSN, AAS joined the Brown Consulting team in 2016. She earned a Bachelor of Science degree in Nursing from Idaho State University in 2009. Holly began her transition from a home health/hospice RN to Health Information Management by returning to ISU where she earned an Associate Degree in Health Information Technology and graduated in May 2016. She is eligible to sit for the national RHIT examination.

Although a new Health Information graduate, Holly is no stranger to teaching. As an honor student during her ISU academic years, she was employed by ISU as a tutor. Her training duties included topics such as anatomy, physiology, pathology, biology, ICD-10-CM diagnosis coding, ICD-10-PCS coding, and CPT coding. She also provided EMR training.

Holly is currently helping to develop BCA’s 15-Minute Coding Pearl educational series, which are brief on-demand videos. You are invited to view these videos at codinghelp.com.

Brown’s Commitment  Brown Consulting Associates, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, PCMH programs, value-based reimbursement projects and private insurance carriers. In addition to serving physician offices, Brown Consulting Associates provides specialized training for various third party payers, outpatient hospital-based clinics, and Federally Qualified Health Centers and Rural Health Clinics. Brown Consulting Associates offers physician and staff education designed and customized to enhance quality, operations and federal compliance.

Our association with the American Health Information Management Association, American Academy of Professional Coders, Medical Group Management Association as well as other groups, helps us to stay in touch with current issues and trends. Our programs and services are designed to assist physicians and their staff to meet the new demands and challenges of coding, documentation, compliance and reimbursement. Customized in-office services and web-based programs designed to educate clinicians, coders and staff will continue to be our focus.
**Why Is This Topic Important?**

1. Multiple techniques exist for coding the same service.
2. “Coding conflict” exists. Third-party payers, including Medicare have applied various payment rules which are not necessarily consistent with CPT coding guidelines.
3. “Appropriate” coding is controversial among clinicians, coders and payers.
5. A written coding policy for non-displaced fractures should be in place.

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**Resources First!**

*Reference Links Throughout Slides*

2. Medicare Physician Fee Schedule Data Base (current year)
3. NCCI/CCI Section Chapters & Bundling Edits
4. American Academy of Orthopaedic Surgeons (AAOS) books, publications and training
   - Medicare Claims Processing Manual
   - Medicare Benefit policy Manual
     - Also CMS MedLearn articles and other CMS publications
Clinic Note
Scaphoid Fracture

Know the Anatomy


Scaphoid Fracture

CHIEF COMPLAINT: Left wrist fracture. HPI: Patient is an 86 yo female who presents to clinic today after a fall on her outstretched hand four days ago. Reviewing ED records and interview with patient reveals a scaphoid x-ray of the left hand. This was splinted by the ED with a well-padded short arm splint. Patient is right-hand dominant. Some swelling and discoloration of her fingers, she denies any numbness or tingling but does admit to pain (3 of 10). She normally lives independently with assistance. She normally ambulates with the assistance of a walker. She is a limited community ambulator.

SURGICAL HISTORY
Renal tumor removed 1990. Right femur fracture w/ IM nailing Dr. XXXXXXXX 2009.

REVIEW OF SYSTEMS
 Constitutional: Patient appears to be at rest, age, presents appropriately, and is in reasonable overall health. Cardiovascular: No problems, no chest pain, no recent changes. Respiratory: No problems, shortness of breath, no recent changes. Musculoskeletal: See above history and see below physical exam.

PHYSICAL EXAM
VITAL SIGNS: BP 113/67 mmHg | Pulse 78 | Temp (Forearm) 36.9 °C (98.4 °F) | (Temporal) | Resp 16 | Ht 1.75 m (5’9”) | Wt 68.127 kg (150 lb 1.6 oz) | BMI 30.4 kg/m2 | SpO2 97%


Musculoskeletal: On physical examination today the patient's left arm cast is removed. Skin is grossly intact. Swelling and tenderness to palpation about the wrist. No pain with gentle circumduction of the shoulder. Elbow exam is unremarkable. Sensation is intact distally. Palpable pulses. ROM of unaffected left upper extremity joints WNL.

Imaging: AP and lateral view of the left wrist and forearm are examined. Independent review of plain radiographs: reasonable radial length. Bone density is acceptable for age. A nondisplaced left scaphoid fracture is identified.

ASSESSMENT and PLAN
1. Left scaphoid fracture, nondisplaced. Today, patient was placed in a well-padded long-arm cast with thumb spica extension utilizing fiberglass. We will plan to repeat x-rays in 1-2 weeks in clinic. X-rays will include 3 views of the left wrist after removing the cast. My hope is that we can treat this nonoperatively. She should keep her left upper extremity elevated with wrist higher than the elbow higher than the shoulder. Reviewed x-rays.

Know Your Code Data
Physician Fee Schedule Database

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
<th>NON-FACILITY</th>
<th>FACILITY</th>
<th>GLOBE(F)</th>
<th>PRE</th>
<th>INTRA</th>
<th>POST</th>
<th>MULTI</th>
<th>BIAT</th>
<th>ABST</th>
<th>CONV</th>
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<tr>
<td>25622</td>
<td>Treat wrist bone fracture</td>
<td>8.60</td>
<td>7.88</td>
<td>090</td>
<td>0.10</td>
<td>0.69</td>
<td>0.21</td>
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<td>1</td>
<td>1</td>
<td>35.8043</td>
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<tr>
<td>25624</td>
<td>Treat wrist bone fracture</td>
<td>13.54</td>
<td>12.36</td>
<td>090</td>
<td>0.10</td>
<td>0.69</td>
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<td>20.66</td>
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<td>10.85</td>
<td>090</td>
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<td>0.69</td>
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<td>9.10</td>
<td>090</td>
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<tr>
<td>25651</td>
<td>Pin ultral styloid fracture</td>
<td>13.85</td>
<td>13.85</td>
<td>090</td>
<td>0.10</td>
<td>0.69</td>
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<td>1</td>
<td>1</td>
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<td>25652</td>
<td>Treat fracture ulnar styloid</td>
<td>17.78</td>
<td>17.78</td>
<td>090</td>
<td>0.10</td>
<td>0.69</td>
<td>0.21</td>
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<td>25660</td>
<td>Treat wrist dislocation</td>
<td>11.64</td>
<td>11.64</td>
<td>090</td>
<td>0.10</td>
<td>0.69</td>
<td>0.21</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>35.8043</td>
</tr>
</tbody>
</table>

CMS Physician Fee Schedule:
https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/

Choices for CPT “Fracture Care Codes”

*Consider All Three Codes as “Major Surgeries”*

<table>
<thead>
<tr>
<th>Code</th>
<th>CPT DESCRIPTION</th>
<th>RVU</th>
<th>Medicare Data Base</th>
<th>Medicare Allowable</th>
<th>Medicare Denier Charge Medicare</th>
<th>FQHC PPS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>25628</td>
<td>Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed</td>
<td>20.6</td>
<td>90</td>
<td>$739.72 (done in hospital)</td>
<td>$1,244.00 (done in hospital)</td>
<td>NA</td>
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<tr>
<td>25624</td>
<td>Closed treatment scaphoid (navicular) fracture; with manipulation</td>
<td>13.5</td>
<td>90</td>
<td>$484.79 (in clinic)</td>
<td>$1,283.20 (in clinic)</td>
<td>NA</td>
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<tr>
<td>25622</td>
<td>Closed treatment scaphoid (navicular) fracture; without manipulation</td>
<td>8.64</td>
<td>90</td>
<td>$309.36 (in clinic)</td>
<td>$681.30 (in clinic)</td>
<td>NA</td>
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</tbody>
</table>

Three Scaphoid “Fracture Care Codes”

*Based on Treatment Technique Used*

1. Most Invasive Treatment
   - CPT 25628
   - Displaced, open reduction is needed w/ internal fixation (ORIF)

2. Moderately Invasive Treatment
   - CPT 25624
   - Displaced, closed reduction is needed

3. Least Invasive Treatment
   - CPT 25622
   - Non-displaced, closed no reduction required

Global Surgical Package

*Open reduction/repair, with internal fixation*

1. Most Invasive Treatment

   1. Code initial visit
      *Use -57 if appropriate*
   2. Code 25628 open surgical procedure
   3. Code x-rays done in clinic
      
      **Do not code** initial cast or splint

      **Do not code** follow up visits; use instead 99024 NC (for 90 day FU period)

   **Always code CPT 25628**
   Open treatment of scaphoid fracture, includes internal fixation, when performed.

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Global Surgical Package

*Closed reduction/manipulation*

2. Moderately Invasive Treatment

   1. Code initial visit.
      *Use -57 if appropriate*
   2. Fracture care code 25624, Closed treatment scaphoid fracture with manipulation is assigned.
   3. Code x-rays done in clinic.
      
      **Do not code** initial cast/ or splint fabrication/application.

      **Do not code** follow up visits, use instead 99024, no charge, (for 90 day follow-up period)

   **Always code CPT 25624**
   Closed treatment of scaphoid fracture with manipulation/reduction
The Non-displaced Fracture

“No Reduction” At All - Two Techniques for Coding

3. Least Invasive

Two options CPT 25622
Closed treatment of scaphoid fracture without manipulation.

Coding Technique #1
Itemize all services.

Coding Technique #2
Apply the Global Surgical Package with CPT code 25622.

Do not code initial cast or splint fabrication/application.

Do not code follow up visits, use instead 99024, no charge, (for 90 day follow-up period).

The Non-displaced Fracture

No Reduction/Fixation Required

Technique 1
Itemize Coding

1. Code initial E/M visit. *Use modifier 25 if appropriate*
3. Code cast fabrication.
5. Code all follow-up visits (likely 99212 or in some cases, 99213).

Technique 2
Global Surgery Package Coding

1. Code initial E/M visit. *Use modifier 57 if appropriate*
2. Code x-rays done in clinic.
3. Code 25622 Closed treatment scaphoid fx w/o manipulation.
   *Do not code* initial cast/or splint fabrication/application.
   *Do not code* follow up E/M’s Assign 99024 for no charge visits during the 90 follow-up days.

Tips for Coding Policy Creation

*If Possible, Policies Should be Limited to One Page*

1. Involve clinicians in the decision making process.
2. Research & provide policy-based literature review references to support policy decisions.
3. Provide brief “Proposed Policy Change” to interested parties.
4. Include all-staff education.
5. Include patient education instructions for nursing, front desk and coding billing as appropriate.
6. Avoid an abundance of “code talk” - write the policy in an easy-to-understand fashion, include resource list, have policy “signed-off” by participating staff.
7. Policy should include date, planned review date (one year), work flow and signatures of approvers.
8. Include a re-review date.
Start Policy With Clear Information
If Possible, Policies Should be One Page

NCCI/CCI
Medicare’s “Bundling” Edits

“CCI Edit Revision Date 1/1/16
F. Fractures, Dislocations & Casting
“14. If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment w/o manipulation CPT code may be reported.”
“...If a single cast, or splint treats multiple fractures without manipulation in addition to one with manipulation, a closed fracture without manipulation CPT code should not be reported separately.”

Frequently Asked Question

1. What coding technique does Brown Consulting recommend, as a matter of general clinic policy, for non-displaced fractures that do not require manipulation or reduction?

Generally, BCA recommends Technique 1, Itemized Coding.

1. E/M code-25 (fully documented)
2. Any x-rays taken in clinic (7XXXX) Modifiers 26/TC may apply
3. Cast/splint fabrication [application] code (29XXX)
4. Supplies purchased by you (HCPCS AXXX, or QXXXX codes)
5. All follow-up E/M visit services are coded
6. Note: For FQHC/RHC patients, consider only Technique 1

Note: Modifier 25 not really required but may be necessary for some payers indicating E/M was separately necessary and separate work from cast application.

Frequently Asked Question

2. The Medicare patient has non-displaced fracture of two metacarpals in the left hand.

CPT Code Description
26600 Closed treatment of metacarpal fracture without manipulation, each bone

Question: When using Technique 2, Global Surgical Coding Technique, do we assign code 26600 twice?

If the patient is Medicare, the answer is no. If the patient is not Medicare, you have a choice. CPT description indicates two units of 26600 could be coded - significantly increasing the charge. By contrast, Medicare’s CCI instructs that 26600 will be assigned only once for similar non-displaced fractures in the same anatomical area and treated with the same cast/splint.
Scenario - Technique 1

3. Patient is involved in an accident has two non-displaced left hand metacarpal fractures. 
(a) non-displaced fracture left 2\textsuperscript{nd} metacarpal 
(b) non-displaced fracture left 3\textsuperscript{rd} metacarpal 

**Question:** Using Technique 1, Itemized Coding, how is the initial encounter/visit coded?

1. Assign E/M visit code with modifier 25 (as appropriate)  
2. Any x-rays if taken in your clinic (7XXXX)  
3. Fabrication [application] of cast/splint (29XXX)  
4. HCPCS code cast supplies (AXXXX or QXXXX)  
5. All casts/splints applications and supplies are coded  

*All follow-up visits, services and supplies are coded*

Scenario - Technique 2

4. Patient suffers two non-displaced left hand metacarpal fractures.  
(a) non-displaced fracture left 2\textsuperscript{nd} metacarpal  
(b) non-displaced fracture left 3\textsuperscript{rd} metacarpal  

|26600| Closed treatment of metacarpal fracture without manipulation, each bone |

**Question:** Using Technique 2, Global Surgical Package Coding, how is the initial encounter/visit be coded?

1. E/M-57, if appropriate and documented  
2. 26600 (once)  
   ➢ Medicare’s CCI logic = Two fractures treated with the same cast  
3. Any x-rays taken in your clinic (7XXXX)  
4. First Cast/splint fabrication, 29XXX, is not coded.  
   ➢ Follow up casts and splints are coded and billed.  
5. No charges for the first 90 day follow up visits.
Different Hands - Technique 2

5. If a patient is involved in a motorcycle accident and suffers non-displaced fractures in both hands.
   (a) non-displaced fracture, **left** 2\textsuperscript{nd} metacarpal
   (b) non-displaced fracture, **right** 2\textsuperscript{nd} metacarpal

\[26600\] Closed treatment of metacarpal fracture without manipulation, each bone

**Question:** Using Technique 2, *Global Surgical Package Coding*, how would the initial visit be coded?

1. E/M-57 (initial evaluation to determine need for surgery)
2. X-rays taken in your clinic are always coded
   *Medicare’s CCI logic = different hands, & different casts*
3. 26600-LT for the left hand fracture
4. 26600-RT (or -59) for the right hand fracture (50%)
5. First cast/splint fabrication, 29XXX, is **not** coded
   - Follow-up cast work and supplies **are** coded & billed
6. No charges for first 90 days of follow up care (99024)


Different Hands - Technique 1

6. If a patient is involved in a motorcycle accident and suffers non-displaced fractures in both hands.
   (a) non-displaced fracture, **left** 2\textsuperscript{nd} metacarpal
   (b) non-displaced fracture, **right** 2\textsuperscript{nd} metacarpal

**Question:** Using Technique 1, *Itemized Coding*, how would the initial visit be coded?

1. E/M-25 (as appropriate)
2. X-rays taken in your clinic - **OK with either technique.**
3. Fabrication [Application] left cast/splint (29XXX-LT)
4. Fabrication [Application] right cast/splint (29XXX-RT)
5. Supplies for casts/splints (HCPCS AXXXX or QXXXX)

   **All follow-up visits, services and supplies are coded**

In Summary

1. For the care and treatment of non-displaced fracture, determine what coding technique will be used by your clinic;
   - **Technique 1 - Itemize all services**
   - **Technique 2 - Global Surgical Package Coding**
2. Write and share the policy.
3. Monitor the coding and reimbursement.
4. Revise the policy as necessary.

Thank You

Do You Have Questions?

You may send your coding questions to us.

**codingquestions@codinghelp.com**
CPT
American Medical Association

- CPT 2016, General Instructions, Surgical Instructions, Musculoskeletal Guidelines
- Principles of CPT (AMA publication)
- CPT Assistant (AMA, monthly coding guidance articles and coding directives)
  https://commerce.ama-assn.org/store/

AAOS
American Academy of Orthopaedic Surgeons

- AAOS Musculoskeletal Coding Guide 2016
  AAOS.org
- Coding for Closed Treatment of Fractures
  Mary LeGrand, RN, MA, CCS-P, CPOC
  http://www.aaos.org/search.aspx?id=32&srchtext=Mary+LeGrand%2c+RN%2c+MA%2c+CCS-P%2c+CPC
General Training Disclaimer

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Coding Pearl Evaluation - Brown Consulting

Please scan & email to laura@codinghelp.com or fax to 208-736-1946

Your web based training session:

1. Did you watch the entire training?  ❑ Yes  ❑ No

2. Rate your coding competence prior to training.
   ❑  ❑  ❑  ❑  ❑

3. Rate the training.
   ❑  ❑  ❑  ❑  ❑

4. Did you find this training process valuable?  ❑ Yes  ❑ No

5. Will your coding change as a result of training?  ❑ Yes  ❑ No

Please note any recommendation for improvement of this training program:

Please note any comments or recommendations you may have for administration:

Please note any follow-up you are requesting from the trainer: