Coding for Multiple Metatarsal Fractures, Bunionectomy with Exostectomy

Here's some advice for their appropriate billing.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

Coding the Performance of Multiple Closed Metatarsal Fractures

Question: *"The emergency department referred me a patient with three non-displaced metatarsal fractures right foot. I billed CPT 28470 x3, which is defined as 'closed treatment of metatarsal fracture; without manipulation, each'. My MAC approved one. When we queried why only one fracture care was paid, our Medicare rep stated that the MUE only allows for 2 fracture care code approvals.*

While I understand that is not 'typical' that a patient has three fractures (versus one), the patient has three distinct fractures that I am responsible for treating. Any of the fractures could heal normally...or not—displace, gap, mal-align, slow heal, or not heal. There must be a reason CPT defines the code as 'each'. I would like to know 'why' I'm being denied and what is wrong in my appealing this denial?"

Answer: Medicare, in my opinion, has unilaterally deviated from standard CPT language, and set up a reimbursement policy that may significantly differ from non-Medicare payers.

CPT describes CPT 28470 as "closed treatment of metatarsal fracture; without manipulation, **each.**" [emphasis added]

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The National Correct Coding Initiative (CCI) (CMS/Medicare) notes in its guidelines:

"15. When a fracture or dislocation is repaired, only one fracture/dislocation repair code may be reported. Closed repair codes, percutaneous repair codes, and open repair codes for the same anatomic site are mutually exclusive of one another, and only one of these codes may be reported for the repair of a fracture or dislocation at an anatomic site.

16. If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment without manipulation CPT code may be reported. Additionally, if a single cast, strapping, or splint treats multiple fractures without manipulation in addition to one or more fracture(s) with manipulation, a closed fracture without manipulation CPT code should not be reported separately. These policies also apply to the closed treatment of multiple fractures not requiring application of a cast, strapping, or splint. Thus, if multiple closed fractures occur in an area that would have been treated with a single cast, strapping, or splint, only one CPT code for closed fracture treatment without manipulation may be reported. If a cast, strapping, or splint applied after an open or percutaneous treatment of a fracture also treats a closed fracture without manipulation, a closed fracture without manipulation CPT code should not be reported separately. These principles also apply to the treatment of multiple dislocations or combinations of multiple

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closed fractures and dislocations. If multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported.

Additionally, if a single cast, strapping, or splint treats any combination of closed dislocations and/or closed fractures without manipulation in addition to at least one closed dislocation or fracture that did require manipulation, only a single CPT code for closed treatment with manipulation of the dislocation or fracture may be reported. Similarly, if multiple dislocations and/or fractures are treated with or without manipulation and do not require a cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment CPT code may be reported for the anatomic area that would have been treated by a single cast, strap or splint. Finally, if a cast, strapping, or splint applied after an open or percutaneous treatment of a dislocation and/or fracture also treats a closed dislocation and/or fracture that did not require manipulation, a CPT code for closed dislocation or fracture treatment (without manipulation) should not be reported."

What we have is CMS-made coding conflict regarding interpreting and implementing CPT 28470 code descriptions versus the CPT language:

CPT code description including "each" (by the way, CMS was "at the table" when that description was adopted at CPT) appears pretty clear and not readily subject to any interpretation. The value of each closed with manipulation metatarsal fracture treatment—already the lowest of the global metatarsal fracture care codes—is annually subject to re-valuation by CMS. If more than one fracture care code is billed, subsequent code values are reduced by half (multiple surgery rules).

The CCI/CMS, ignoring the above, lumps the treatment of multiple closed metatarsal fractures on the same foot into a maximum reimbursement of one. They set the MUE (Medically Unlikely Edits) at "2" (1 unit for the right foot and 1 unit for the left foot). I'm sure their thinking [sic] is that the doctor's primary treatment is the application a single below-the-knee cast whether there are one, two, or three uncomplicated metatarsal fractures, so why pay for treating more than one fracture?

The problem is that each metatarsal fracture is unique, and may demonstrate that uniqueness in its healing rate over the 90-day global period. With multiple fractures on a foot, one can reasonably argue that more attention to the overall healing of the patient is necessary by the doctor; that more post-operative visits could occur, especially in the patient who may need more than the usual number of post-operative x-ray studies or visits because of reported pain/aching, prolonged swelling, or added time to transition to "regular" footwear or higher risk of potential complications with the presence of three fractures versus one fracture. Then there is the potential for greater physician liability risk beyond that "allocated" to a single code value. After all, the doctor is dealing with three fractures instead of one. Two could heal; one could get a pseudo-arthrosis requiring additional attention and potential future surgical correction.

My personal opinion is that if you feel that you are correct in billing three separate ("each") closed metatarsal codes in the treatment of your patient, then, unless or until CPT changes their description language, you should bill what you believe is correct coding given the work you performed. A warning regarding Medicare: expect a denial of treatment codes beyond one—but appeal any denial if you believe you are correctly following CPT language and intent. With non-Medicare payers, you will probably, depending on where you practice, find that many payers still follow CPT.

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Bunionectomy with Exostectomy Base of the Proximal Phalanx

Question: *"I performed a modified McBride-type bunionectomy with sesamoid release, etc. and clean-up of arthritic hallux phalangeal base due to degenerative changes. I am being denied the CPT 28124 hallux exostectomy because the two procedures were done through the same incision—which is true. However, I was under the impression that since the surgery was done on two separate bones and billed as two separate sites (foot for CPT 28292 and 1st toe for CPT 28124) both should be payable. Am I wrong in my thinking?"*

Answer: Yes, you are wrong in your thinking. I would not get hung up on whether something is done through the same incision. This is a false premise. The point is not whether the procedures are done through one incision, but whether these are separate distinct procedures, each worthy of being "comprehensive" versus one being a component of the other. In this case, is a partial ostectomy of the base of the proximal phalanx performed during performance of a bunionectomy included in the bunionectomy allowance (i.e., as a component procedure), or is it an independent procedure?

The answer is that remodeling the base of the proximal phalanx is included in the allowance for CPT 28292. Think about it for a second. CPT 28292 is described as "correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method". You are asking about a separate billing for a "clean up of arthritic hallux phalangeal base." I think it is safe to presume that any partial ostectomy

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of the hallux base, same site as the bunionectomy performance, would be included in the allowance for CPT 28292. By the way, would any of the bunionectomy procedures (CPT 28292-28299) include any partial ostectomy remodeling of the base of the proximal phalanx? No, because it was performed through the same incision, but because bunionectomy procedures are "global packages" that include specific work around the first metatarsal-phalangeal joint, both osseous and soft tissue to 1) elimination of the bony prominence (bunion); 2) removal of any exostosis or prominent bone in the site (including around the base of the proximal phalanx), if necessary; 3) sesamoidectomy, if necessary; 4) soft tissue pliation or releases; 5) tendon balancing; and 6) fixation.

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If you felt that in your case there was excessive work done (and documented) "above and beyond" what is included in CPT 28292, you could try to append the code with a "-22" modifier. It will be manually reviewed so include an op report and a letter of explanation with your claim. Also, request peer review. You should be aware that the only thing guaranteed about applying a "-22" modifier is weeks, maybe even months, of delay in processing your claim.

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the *Podiatry Management* Lifetime Achievement Award.