

# ORTHOPAEDIC POTPOURRI

## FRACTURE MANAGEMENT AND BEYOND

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1

## OBJECTIVES

- Fracture coding, what do you need to know?
  - Types of fractures
  - Types of treatment
  - “Fracture care”
  - ICD-9 diagnosis guidelines
  - A glimpse of fractures in ICD-10
- CCI guidelines musculoskeletal
- Musculoskeletal injections and meds
- The Orthopedic Operative Report
- Radiology quirks
- Injection pearls

2

## **DISCLAIMER**

This presentation is for education purposes only. The information presented is not intended to be legal advice. The information presented was current at the time presented and when applicable, based upon guidelines published by the AMA, CMS, and NCCI.

3

## **FRACTURES**

### **What Do You Need To Know Before You Code?**

- Fracture definition
- Location
- Configuration
- Alignment
- Type of treatment

4

## WHAT IS A FRACTURE?

“A break or disruption in the continuity of a bone, epiphyseal plate or **cartilaginous** surface”

Blauvelt and Nelson

5

## LOCATION

- The specific bone(s) involved
- Where on the bone

6

## **ANATOMICAL TERMINOLOGY**

- Epiphysis-bulbous proximal or distal end of a long bone
- Metaphysis-section of bone between the epiphysis and diaphysis of a long bone
- Diaphysis-shaft of long bone
- Physis-growth plate

7

## **OPEN VS. CLOSED FRACTURE**

- Open fracture shows communication of the fracture with the outside environment
- Simple puncture wound to massive open near amputation
- The bone can produce the opening or the opening can produce the fracture

8

## OPEN VS. CLOSED FRACTURE

- Closed has no break in the skin that communicates with the fracture
- Open wound  $\neq$  Open fracture
- The key: do the fracture and the wound communicate with each other?

9

## TYPE OF TREATMENT

- Closed
- Open
- Percutaneous skeletal fixation

10

## TYPE OF TREATMENT....

- Type of manipulation
  - Defined by CPT as the *attempted* reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces
- Type of stabilization
  - Internal
  - External
    - Pins and frame
    - Cast/brace
  - Percutaneous

11

## TYPE OF TREATMENT OPEN

- Fracture is visualized with naked eye
- Internal or external or no fixation
  - Sometimes both
  - Internal fixation can be placed percutaneously
- ≠ Open FRACTURE

12

## TYPE OF TREATMENT

### OPEN

- IM (intramedullary) rodding
  - Bone is opened remote from the fracture site
    - Rod is placed down the intramedullary canal
    - Often screw fixation is placed at the proximal and distal ends to prevent movement of the rod
  - Fracture is visualized only by x-ray
  - If no CPT code descriptor for IM rodding should be coded as open
    - CPT Musculoskeletal System Chapter guidelines

13

## TYPE OF FRACTURE

### OPEN

- If open fracture was debridement performed?
  - Debridement of open fractures 11010-11012 NOT 11010-11044
    - Also for debridement of open dislocations
    - Includes exploration of the wound
  - Debridement of open fractures can be repeated/staged
    - Continue to report with 11010-11012 until definitive management of the fracture performed
    - Attach 58 modifier
    - Once fracture has been treated and treatment is directed at management of the wound report wound management codes
  - Can be reported multiple times on same claim if different fractures and/or different levels of debridement
    - Mod 59

14

## **TYPE OF FRACTURE OPEN**

- Debridement is more than washing/irrigating with “copious amounts” of antibiotic solution
- Documentation is the key
  - The level of tissue debrided
  - Debris or other “junk”
  - Wound may or may not be closed
- Described in CPT as extensive, intensive

15

## **TYPE OF FRACTURE OPEN**

- An OPEN fracture can be treated CLOSED with or without reduction

16



## **TYPE OF TREATMENT**

### **PERCUTANEOUS SKELETAL FIXATION**

- Treatment is neither open nor closed
- Fracture fragments are not visualized
- Device is inserted through the skin with a minimal incision
  - May be seen with open treatment
- Usually done with imaging (fluoro, C-arm)
  - Use of imaging during the procedure is included in the procedure

17

## **TYPE OF TREATMENT**

### **CLOSED**

- Manipulative reduction
  - In other words, did the physician push on the fracture to reposition the bone
  - Sometimes this is done when the cast is applied
  - Cast application with “molding”
  - Wedging of cast
  - Look for post-reduction/casting x-rays

18

## **TYPE OF TREATMENT CLOSED**

- Closed management or “Fracture Care”
- In other words, no reduction

19

## **NON-MANIPULATIVE FRACTURE CARE**

20

## AKA Ruby's rule

- With a few exceptions, if it is broken and a treatment/procedure is performed bill for the global service of management of the fracture

21

## FRACTURE CARE THE RULE OF THREE

### Rule #1

- Confirmed fracture diagnosis
  - ≠ Possible, probable, maybe, appears to be

22

# FRACTURE CARE

## THE RULE OF THREE

### Rule #2

- Institution/continuation of treatment
  - i.e. stabilization of the fracture
  - **NOT ALL FRACTURES WILL BE TREATED WITH A CAST**
    - Orthoses such as CAM walkers, Sarmiento sleeve
    - Fractures such as the proximal humerus, scapula, radial head and neck and clavicle cannot be immobilized in a cast
    - Standard of care is treatment in a sling

23

# FRACTURE CARE

## THE RULE OF THREE

### Rule #3

- Planned follow up

24

## FRACTURE CARE

- If plan is for manipulative procedure at a future date, non-manipulative fracture management should not be billed
- If treatment is instituted, with the possibility for a manipulative procedure at a future date, bill non-manipulative fracture management
  - Determination of subsequent procedure is dependent upon maintenance of fx position w/o addl treatment
  - Addl procedure will require -58modifier

25

## FRACTURE CARE EXCEPTIONS

No one's rule

- Phalangeal fractures treated w/buddy taping
- Pelvis fracture (excluding acetabulum)
- Metatarsal fracture treated w/stiff soled shoe

26

## **FRACTURE CARE EXCEPTION VERTEBRAL BODY FRACTURES**

CPT 22310

“Closed treatment of vertebral body fracture(s) w/o manipulation, requiring and including casting or bracing”

27

## **FRACTURE CARE EXCEPTION VERTEBRAL BODY FRACTURES**

CPT 22310

Per the AMA CPT Assistant June 2006, Volume 16, Issue 6, page 16

*“In order to report the casting or strapping codes, the procedure must be performed by a physician or by other personnel under the direct supervision of a physician. As direct supervision indicates, the physician **MUST BE PRESENT DURING THE PROCEDURE** when a nonphysician is performing the splint application”*

28

## **FRACTURE CARE EXCEPTION VERTEBRAL BODY FRACTURES**

CPT 22310

What does this mean?

If the orthotist applies a TLSO (back brace) without the presence of the physician, no fracture care can be billed.

29

## **FRACTURE CARE VS. ITEMIZED?**

- In general, reimbursement is nearly equal for fracture management vs. E&M
  - Initial cast application cannot be billed with fracture management, may be billed with E&M if meets -25 modifier criteria
  - Subsequent casts may be billed for both
  - Cast materials can be billed for both
  - X-rays can be billed for both
  - E&M cannot be billed for either situation if the primary reason for the visit is a cast change (-25 modifier criteria)

30

## **FRACTURE CARE VS. ITEMIZED?**

The bottom line.....

### **THERE IS NO WRITTEN RULE**

- The decision to bill fracture care vs. itemized is ultimately an internal business decision
- Suggest development of policies so that all coders/physicians are consistent
- CMS is reviewing global period
- CMS does not expect charges for itemized billing to far exceed that of global fx care

31

## **FRACTURE CARE VS. ITEMIZED?**

If decision is to bill global fracture care,  
make sure patient is informed.

32



## **NON-MANIPULATIVE FRACTURE CARE CCI**

January 1, 2013 Manual Revision

“If a cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture without manipulation CPT code may be reported.”

33

## **NON-MANIPULATIVE FRACTURE CARE CCI**

Written inquiry response February 8, 2013

“This policy is applicable to any combination of multiple bone fractures treated with the same cast, strapping or splinting and without manipulation. It is NOT limited to multiple fractures of the same type of bone (e.g. metacarpals, carpals). There is a single 90 day global period applicable to these multiple fractures which includes all the post-operative evaluation and management services related to the closed treatment of the fractures without manipulation.”

34

## NON-MANIPULATIVE FRACTURE CARE CCI

Further response

- Includes non-manipulative management when any additional fracture may be treated with either closed or open reduction and all fractures will be treated with the same immobilization device.

35

## NON-MANIPULATIVE FRACTURE CARE CCI 2014

- Clarified 2013 changes to include much of information obtained with inquiry
- Added “*These policies also apply to the closed treatment of multiple fractures not requiring application of a cast, strapping, or splint.*”

36

## FRACTURE CARE AND E&M

- Per AAOS, AMA and CMS the initial evaluation for treatment and diagnosis of the fracture is billable with a 57 modifier.
- Just because treatment doesn't involve slicing and dicing doesn't mean the same thought process and risk management isn't involved.
- All fracture treatment codes currently carry a 90 day global period and are therefore considered a major procedure.

37

## FRACTURE CARE AND THE ER/UC

- If ER/UC physician makes the diagnosis and applies a splint, the ER/UC physician should bill only for the E&M and splint application

### WHY?

- ✓ No definitive treatment is being provided
- ✓ The ER/UC physician is not assuming care for management of the fracture and the results

This is supported by CMS and the AMA

38

## FRACTURE CARE AND THE ER/UC

CPT introductory guidelines state:

“If a cast application or strapping is provided as an initial service **in which no other procedure or treatment** (eg. surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician *rendering the initial care only*, **use the casting, strapping and/or supply code in addition to an evaluation and management code as appropriate.**”

39

## FRACTURE CARE AND THE ER/UC

- If ER/UC physician makes the diagnosis and performs a reduction, the ER/UC physician should bill the fracture management code with the 54 modifier unless the ER/UC physician provided a significant portion of the post operative care
- Ortho would bill the fracture management code with 55 modifier or for some payors, E&M, subsequent casting codes
  - There must be a written transfer of care from the ER (or other physician) and ortho must accept the transfer of care
  - Claim must note date receiving physician assumed care and initial physician relinquished (Box 19)

40

## FRACTURE CARE AND THE ER/UC

- Reimbursement with the 55 modifier equals the post operative portion of the fee schedule or approximately 20% of the allowable

41

## CAST/SPLINT APPLICATION

- Fracture management, regardless of type is considered a major “surgery” with a 90 day global period.
- Application of the initial cast/splint (not orthosis) is ALWAYS included when billing any form of fracture management
  - Application of an orthosis is not considered application of a cast/splint and should be billed with the appropriate L code only
- Per CMS and AAOS, supplies are not included in the cast application or management of the fracture

42

## CAST/SPLINT APPLICATION

- Although by definition, cast applications fall outside of the global period, Medicare requires a 58 modifier on all subsequent cast applications during the global period.
- Why? Cast application codes have a zero day global period.

43

## CAST/SPLINT APPLICATION

- Effective July 1, 2001, A4570, A4580 and A4590 are no longer valid HCPCS codes
  - 51 Q codes established for cast supplies

44

## CAST/SPLINT APPLICATION Q CODES

- Each Q code includes all of the materials needed for application of the cast with the exception of waterproof cast padding (Gortex/Procel, Delta lite)
  - You should not be billing for multiple units/multiple rolls of material, padding, stockinette, etc.
- Effective 4/1/14 calculation of fee will be based upon national fee schedule not U&C
  - Still submitted to and processed by carrier/MAC under Part B

45

## CAST/SPLINT APPLICATION Q CODES

- Type of cast applied
  - Short arm, long arm, short leg, etc.
- Type of cast material
  - Fiberglass/synthetic or plaster
- The age of the patient
  - Pediatric = age 10 and under

46

## CAST SUPPLIES Q CODES

- Q4006 long arm cast, adult fiberglass
- Q4008 long arm cast, pediatric, fiberglass
- Q4010 short arm cast, adult, fiberglass
- Q4012 short arm cast, pediatric, fiberglass
- Q4030 long leg cast, adult, fiberglass
- Q4032 long leg cast, pediatric, fiberglass
- Q4038 short leg cast, adult, fiberglass
- Q4040 short leg cast, pediatric fiberglass

\*Not all inclusive

47

## CAST SUPPLIES GORTOX/PROCEL

- Q4050
- Description of supply must be on claim
  - “waterproof cast padding short arm cast”
- Some healthplans will want an invoice
- Some Medicare carriers cover only if documentation of medical necessity others do not cover and consider provider responsibility
- Some healthplans do not cover and require ABN to bill patient

48



## STRESS/PATHOLOGIC FRACTURES

- As long as the documentation supports fracture management treatment can be considered fracture management

49

## FRACTURE-DISLOCATION

- If both a fracture and dislocation of the same anatomic site and if both are treated, bill only treatment of the fracture unless there is a combination code (eg. Monteggia, Galeazzi)
- If initial treatment is reduction of the dislocation then separate session for reduction of the fracture, bill the appropriate dislocation reduction code followed by the appropriate fracture reduction code with a 58 modifier

50

## MALUNION-NONUNION

- When available CPT selection should be for repair nonunion/malunion not osteotomy
- If no malunion/nonunion CPT code available, may use fracture treatment code for nonunion repair and generally osteotomy code for malunion repair

51

## DIAGNOSES ICD-9

- Per ICD-9 Guidelines and AHA Coding Clinic the 800 series code should be used when the patient is receiving active treatment for the fracture.
- Active treatment includes surgical treatment, emergency department encounter, evaluation and treatment by a new physician
- 800 series code may be assigned if the patient undergoes a subsequent procedure related to management of the fracture
  - Initial closed reduction followed by ORIF

52

## DIAGNOSES ICD-9

- AFTERCARE V codes should be assigned for subsequent visits following active treatment of the fracture (until 10/1/14)
- V codes should be assigned for routine care during the healing or recovery phase
- V54.1x traumatic fractures
- V54.2x pathologic fractures

53

## DIAGNOSES ICD-9

- Fracture-dislocation-per AHA Coding Clinic Quarter 3 1990 when documented as fracture-dislocation only the fracture ICD-9 should be assigned
  - Dislocation is listed as a non-essential modifier under fracture

54

## DIAGNOSES ICD-9

- Nonunion/Malunion 733.8x relate to nonunion/malunion of fractures only
  - Append late effect fracture 905.2-5 to clarify where the original fracture was
  - No specified time frame for non-union; should be assigned per physician documentation

55

## DIAGNOSES ICD-9

- Multiple fractures should use multiple diagnosis codes in order of severity of injury

56

## DIAGNOSES

- Pathologic fracture involves an underlying disease process
- Stress fracture is due to repetitive activity with no trauma

57

## ICD-10 AND FRACTURES

- Specificity for laterality
- Non-union, malunion, delayed union now attached to a specific fracture as 7<sup>th</sup> digit extender
- Specificity for displaced vs. nondisplaced
- 7<sup>th</sup> digit specificity for initial and subsequent encounters, healing vs. delayed vs. nonunion vs. malunion
- Extensive expansion of fracture classifications
- Open fracture classifications based upon Gustillo classification system; carried throughout treatment
- Salter-Harris classification
- Initial fracture category carried throughout course of treatment

58

# MEDICARE NCCI

59

## MUSCULOSKELETAL NCCI

- Arthroscopy
  - Surgical includes diagnostic
  - Diagnostic may be reported w/58 modifier if open procedure determined necessary based upon findings during diagnostic scope
  - Arthroscopic converted to open report only open
  - Recognizes separate compartments of the knee
    - Clarified that G0289 should follow same guidelines as CPT when meniscectomy and debridement involved
  - 2014 cannot report debridement if done with other surgical arthroscopic procedures

60

## MUSCULOSKELETAL NCCI

- Casting/splinting/strapping
  - Not separately reportable following injection/aspiration, debridement procedures, peripheral nerve injections
- Hardware removal
  - Not separately reportable if required to perform another procedure
  - One code/anatomic site regardless of the number of incisions
- Fractures
  - One fracture rule
  - Failed closed procedure converted to open on same day, bill only open
  - Bill only one fracture/dislocation repair code on the same anatomic site on the same day

61

## MUSCULOSKELETAL NCCI

- Shoulder Procedures
  - Does not recognize the shoulder as being three separate “areas” (AAOS defines as GH, AC and subacromial)
  - If bundling edit exists, may only be overridden if separate shoulder
  - Debridement rule w/29826; CCI/Medicare does not believe there is an exception simply because 29826 is add on but due to CPT wording, cannot create an edit (inquiry February 2014)

62

## MUSCULOSKELETAL NCCI

- Spine Procedures
  - Divided into families
    - Multiple procedures from one family performed at contiguous levels, report only one primary code
    - Primary code should be that of the region for the first procedure
    - Multiple procedures from the same family @ different levels but NOT contiguous may report one primary code for EACH non-contiguous region
    - Bone marrow harvesting 38230 should not be reported for aspiration of bone marrow for grafting

63

## MUSCULOSKELETAL NCCI

- Bunions
  - Do not report 1<sup>st</sup> metatarsal (28306/28307) or phalangeal (28310) osteotomy w/ bunion procedures 28290-28299 when done on the same side
  - Do not report 28288 (ostectomy metatarsal head) with bunionectomy code
  - Do not report 28315 (sesamoidectomy) with bunion procedures on the same side. Separate procedure designation.
- Joint Injections/Aspirations
  - Do not report on same joint at same time of an open or arthroscopic procedure

64



## MUSCULOSKELETAL NCCI

- Application lymphedema dressing (29851-29854)
  - Cannot also bill manual therapy/manual lymphatic drainage (97140)
    - This is contrary to 2013 CPT revision
  - Not reportable if treating fracture/dislocation
- MUE's
  - Use F & T modifiers when doing procedures on fingers & toes

65

## RADIOLOGY PEARLS

- Bilateral standing AP knees 73565
  - Per the AMA and ACR should only be billed if this is the only study being performed
  - Otherwise report based upon number of views for each knee
  - If performed and reported, must have an interpretation for each knee otherwise it is simply a comparison film which is generally not covered

66

## RADIOLOGY PEARLS

- One view each Hip with Pelvis
  - Per AMA and ACR should be reported as 73520  
“radiologic exam hips bilateral, minimum 2 views of each hip including AP view of pelvis”

67

## HIP WITH PELVIS

CPT Assistant April 2002

Can code 73520 still be used to report a bilateral hip x-ray performed with two views on each side even if an anteroposterior view of the pelvis is not also performed or is it more appropriate to report code 73510 twice?

According to the American College of Radiology, an anteroposterior (AP) view of the pelvis, as well as additional views of both hips, is the appropriate method of examination when a bilateral hip study is ordered. **In addition to the AP view of the pelvis, at least one more view of each hip, typically a coned-down frog leg lateral view, is obtained amounting to three views: one AP view of the pelvis which includes both hips; one frog-leg lateral of the right hip; and one frog-leg lateral of the left hip.**

However, if a **bilateral study is performed without an AP view of the pelvis**, then code **73520, Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis**, may be reported **with modifier -52, Reduced services**, appended to indicate that the study was not performed in its entirety. CPT code **73510, Radiologic examination, hip, unilateral; complete, minimum of two views**, is not intended to describe a bilateral hip study, but a complete radiological examination with a minimum of two views performed on a single hip.

If right and left hip studies are separately ordered and performed, and there are separate interpretations and written reports signed by the interpreting physician, then it would be appropriate to report the code 73510 two times. In this case, modifier **-59, Distinct procedural service**, should be appended to the second code to indicate that it is a distinct procedure.”

68

## EXTREMITY ULTRASOUND

- 76881 Ultrasound, extremity, nonvascular, real-time with image documentation complete
  - Used when looking at the bone, joint, tendons, ligaments, and all soft tissues in a specific anatomic site of an extremity
- 76882 Ultrasound, extremity, nonvascular, real-time with image documentation, limited, anatomic specific
  - Used when looking at a defined structure in a specific area of an extremity
    - Looking at integrity of a tendon or ligament or at a soft tissue mass
- Both require saved images and “separate” interpretation

69

## NPP GLOBAL RADIOLOGY MEDICARE

- For many carriers requires split billing
- Technical component of radiology service is not considered to be under the PA/NP scope of practice
  - Although most musculoskeletal diagnostic imaging requires only general supervision, the requirement for the technical component is general supervision under a physician
  - PA/NP is not considered a physician
  - PA/NP also does not incur the expense of the equipment or salaries of the technicians which are part of the RVU

70

## NPP GLOBAL RADIOLOGY MEDICARE

NGS Communication January 31, 2013

“Effective January 1, 2013, National Government Services has restored an edit in our claims processing system to not allow payment for global radiologic procedures or the technical component of radiologic procedures when performed by a nonphysician practitioner.

The basis for limiting nonphysician practitioners such as physician’s assistants and nurse practitioners from performing the technical component of x-ray procedures is that this service falls outside the scope of their license. National Government Services will allow nonphysician practitioners to perform the professional component x-rays, therefore the global codes as well as the technical codes will be denied.

Additional guidance can be found in the [Centers for Medicare & Medicaid Services \(CMS\) Internet Only Manual \(IOM\) Publication 100-02, Medical Policy Benefit Manual, Chapter 15, Section 8](#)”

71

## NPP GLOBAL RADIOLOGY

- NGS correspondence dated 1/23/14 allows for global billing of radiology service by PA in MN.
- Not allowed for NPP or CNS
- If test requires physician supervision, may not be performed by PA, NPP, CNS

72

## NPP GLOBAL RADIOLOGY

“Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s) (3) of the Act). However, when these practitioners **personally perform diagnostic tests** as provided under §1861(s) (2) (K) of the Act, §1861(s) (3) does not apply and they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision or collaboration.”

73

## INJECTION PROCEDURES

74

## INJECTION PROCEDURES

- All injections into the same site include aspiration
- Morten's neuroma steroid injections should be reported w/64455 not 64450 and not joint injection
  - If done w/neurolytic agent such as alcohol reported as 64632
  - Should not report both

75

## INJECTION PROCEDURES

- Injection tendon sheath/ligament (20550) vs. origin/insertion (20551) should be specified by provider
  - Trigger finger, deQuervain injections generally are sheath
  - Tennis elbow CPT states to use 20550 sheath however many physicians injection the origin making this injection 20551
  - 20551 not allowed bilateral; must be billed two lines mod RT/LT
  - Check Medicare LCD and payor policies for diagnosis restrictions/medical necessity

76

## INJECTION PROCEDURES

- Injection trigger point
  - Based upon muscle group
  - Should have specific muscle defined
  - 20552 injection 1-2 groups; 20553 + groups
    - Allowed only 1 unit
  - Check Medicare LCD/payor policies medical necessity dx. Eg. NGS 729.5 only
- Ganglion
  - Includes aspiration and/or injection
  - Not allowed bilateral; bill 2 lines mod RT/LT

77

## INJECTION PROCEDURES

- Tarsal Tunnel
  - Medicare WPS and NGS should be billed as unlisted foot procedure 28899
  - Per CPT Assistant should be billed as 64450
- Radial Tunnel/Cubital Tunnel
  - No current literature
- PIN/AIN
  - No current literature
  - Suggest 64450

78

## INJECTION PROCEDURES

- SI Joint
  - Must be done under image guidance (CT/Fluro)
  - Imaging included
  - If done w/o image guidance should be billed as trigger point 20552; consistent with CPT and WPS/NGS
  - Bilateral procedure bill one line w/50 mod
  - For NGS Medicare if unilateral bill w/ RT/LT mod
    - ASC must be billed w/ RT/LT; if bilateral 2 lines RT/LT
    - G0260 to be used only for facilities under OPPS
  - Check LCDs/payor policies for accepted dx
    - Most trigger point policies do not accept joint pain

79

## INJECTION PROCEDURES-XIAFLEX

- Day 1 injection- 20527 injection enzyme palmar fascia cord
  - Generally scheduled injection due to cost of drug therefore E&M w/25 modifier not appropriate
- Day 2 manipulation-26341 10 day global
  - Splinting bundled unless application of finger splint 29130
  - Custom orthosis separately reportable

80



## INJECTION PROCEDURES-XIAFLEX

### Medication Xiaflex

- Only covered dx 728.6 Dupytren's contracture
- Only covered and FDA approved for injection into single cord
- HCPCS reads per .01mg reconstituted = .90mg
  - Standard injection is .58 mg, remainder is discarded
    - Some physicians will inject additional around the cord
  - Some Medicare carriers/payors require billing for wastage
    - Reported two lines J0775
      - J0775 -58 units
      - J0775 JW-32 units
    - All other healthplans bill one line 90 units
- Verify with healthplan if medication to be supplied by specialty pharmacy or if supplied by physician
  - Medicare physician supplied
  - EXPENSIVE

81

## INJECTION PROCEDURES HYALURONATES

- Most healthplans cover for only DJD of the knee
  - Some Medicare contractors are allowing for shoulder
  - Chondromalacia although=early DJD has a separate dx. Therefore is not accepted dx for injections
- Repeated in same joint after 6 months
  - Must show documentation of improvement in pain and functional status after initial injection
- Many healthplans are now either requiring prior authorization or doing retro auths to show attempts at conservative care including past steroid injection and medication, therapy, and radiologic evidence of DJD

82

## INJECTION PROCEDURES HYALURONATES

- Currently seven forms available:
 

Euflexxa J7323	Supartz J7321
Hyalgan J7321	Synvisc J7325
Gel-One* J7326	Synvisc One* J7325
Orthovisc J7324	* single injection
- All except Synvisc is billed as a single unit/injection
  - Synvisc/Synvisc One should specify which medication used
  - Synvisc done in a series of 3; each single joint injection = 16 units
  - Synvisc One is single injection; each single joint injection = 48 units

83

## INJECTION PROCEDURES HYALURONATES

Check Medicare LCD/healthplan policies

- RT/LT modifier?
  - On injection AND medication?
- MEDICATION
  - If requires laterality modifier bill 2 lines
  - EJ modifier?
    - Appended to subsequent injections of a series
    - Should not be appended to the initial injection
- Allow for shoulder and knee?

84

## INJECTION PROCEDURES STERIODS

- Celestone Soluspan J0702 comes as 6mg/ml
  - HCPCS reads per 3mg of betamethasone acetate *and* 3 mg betamethasone sodium phosphate
  - Billing is based upon the combination of these two as a single unit thus 1ml injection is 2 units
    - Think of oil and vinegar, once combined unable to determine amount of each
- Depo-Medrol is not a unit based code
  - Separate codes for 20mg J1020, 40mg J1030 and 80 mg J1040
  - Documentation needs to either reflect the mg injected or if in ml/cc must indicate the base concentration
    - Base medication is 40mg/ml; patient is given 2 ml injection; billed as J1040 80 mg NOT J1030 x2 units
    - NDC to be that for base medication
    - If greater than 80 mg
      - Per HCPCS may bill as a combination of HCPCS codes to reflect the proper dose

85

## CODING FROM THE OP REPORT

- Know your anatomy and even if you do have a good anatomy reference available
- Code from the BODY of the op note
  - Use the headers as your guideline of what to look for
  - Ignore procedures defined by eponyms. Use what is documented
- Medical terminology IS important
  - -ectomy vs -otomy
    - If an -otomy is being done we should be seeing something then being closed or moved or held together
    - -ectomy removed/excised
  - -plasty repair or restoration or reshaping
  - -rrhaphy surgical suturing
  - -desis bind together
- Imperative to know what specific bone/tendon/ligament is being fixed
  - ORIF of an ankle fracture or excision of a TMT bone spur requires a query for the specific bone(s) involved
- ALWAYS check your bundling. Not all edits make sense
  - Remember separate procedures are inherently bundled. They may not show up in the edit.

86

## **ARTHROSCOPIC SHOULDER DECOMPRESSION**

- January 2013 CPT changed to an add on code
- Can only be reported if another shoulder arthroscopic procedure is being billed (procedures allowed are defined in CPT)
- What if it is the only procedure performed?
  - Per CPT Assistant bill as either 29822 debridement limited or 29823 debridement extensive
    - Extensive would be decompression plus documentation of additional extensive debridement
- What if it is the only arthroscopic procedure done with open procedures?
  - Per AAOS using the CPT Assistant information bill using the debridement codes
  - Caution however as 29822 frequently bundled

87

## **ARTHROSCOPIC SHOULDER DECOMPRESSION**

- Billing with rotator cuff repairs
  - Both arthroscopic, no edits
  - All open procedures (23410, 23412, 23420) both open and arthroscopic are bundled in CCI not in AAOS.
    - CPT Assistant currently does not address arthroscopic acromioplasty w/open cuff repairs
    - CPT Assistant does state that open acromioplasty IS bundled with both 23410 and 23412. It is inherently part of 23420.
    - If billing under Medicare -59 modifier is not acceptable based upon 2013 NCCI changes unless contralateral shoulder
  - August AAOS Now has article on appealing (good luck!)

88

## ROTATOR CUFF DIAGNOSES ICD-9

- 727.61 rotator cuff complete=a complete tear of any of the 4 tendons/muscles (Coding Clinic)
- 726.13 partial tear rotator cuff=partial tear of any 1-4 of the tendons/muscles
- 840.4=rotator cuff CAPSULE
- 840.3, 840.5, 840.6 defines the specific tendon/muscle and should be used if documented
- 840 series is for acute tears; tears that have involved an injury; no definition as to complete or partial

89

## ROTATOR CUFF REPAIRS

- Four code choices
  - 29827 arthroscopic
  - 23410 acute tears (not defined)
  - 23412 chronic tears (not defined)
  - 23420 reconstruction
    - Reconstruction involved moving around tissue, using graft jackets or graft material
    - Includes acromioplasty in code description
    - Physicians will document as reconstruction when it is repair by code description
  - “mini-open” = open

90

## BUNIONS

- Ignore eponyms
- Read body of note,
  - -otomy vs –ectomy
  - Metatarsal, phalangeal, both
    - proximal, distal both
  - -desis/fusion

91

## BUNIONS

- 28290- removing the boney bump
- 28292 removing the bump and doing a distal soft tissue release
  - Modified McBride
- 28296-correction by metatarsal osteotomy
- 28298-correction by phalangeal osteotomy
- 28299-double osteotomy
  - Includes phalanx and DISTAL metatarsal or double metatarsal
- 28297-Lapidus fusion of the proximal 1<sup>st</sup> TMT joint AND distal soft tissue release
- If diagnosis is hallux valgus, this series of codes are to be used.

92

## BUNIONS

- All include removing of the bony prominence, capsulotomy, arthrotomy, synovial biopsy, synovectomy, tendon release, tenotomy, tenolysis, excision of medial eminence, excision of associated osteophytes, placement of internal fixation, scar revision, articular shaving, and removal of bursal tissue when done at the first MTP joint
- Cheilectomy-28289, excision of osteophytes of the proximal phalanx and distal metatarsal is done for hallux rigidus
  - Although not part of the bunion procedures, procedures to also correct bunion deformities are bundled into the cheilectomy

93

## BUNIONS DIAGNOSIS ICD-9

- Bunion i.e. the bump 727.1
  - Also the code for bunionette or Tailor's bunion or baby bunion-bony prominence of the 5<sup>th</sup> not 1st
  - ICD-10 bunion takes you to hallux valgus; bunionette becomes other specified deformity
- Hallux valgus-inward turning of the great toe 735.0
- Hallux varus-outward turning of the great toe 735.1
- Hallux interphalangeus- rotational deformity of the great toe at distal phalanx 735.8
- Metatarsus primus varus-movement of the 1st metatarsal away from the midline 736.79 NOT 754.52 unless specified as congenital

94

## ICD-9 DIAGNOSIS

- Osteoarthritis/DJD not specified as generalized should be coded as 715.3x not 715.9x (Coding Clinics)
  - Involvement of bilateral joints is not considered generalized
- Don't forget your secondary DJD codes and late effect
- Include codes for genu valgum/varum 736.4x as these can impact the difficulty of the procedure
- Include code for protrusio acetabulum 718.65 if documented
- Aftercare following joint replacement V54.81
  - Plus V43.6x for type of joint replaced
  - If submitting claims for PT/OT post joint replacement, remember to add the V43.6x series

95

## ICD-9 DIAGNOSIS REVISION ARTHROPLASTY

Revision arthroplasty= Complication

- Mechanical internal ortho device
  - Prosthetic joint
    - 996.41 loosening
    - 996.42 dislocation/instability/subluxation
    - 996.43 broken (prosthesis not bone)
    - 996.44 peri-prosthetic fracture
      - i.e. fracture around the prosthesis
      - If a result of trauma use 800 series code in addition to 996.44
    - 996.45 osteolysis
      - + addl code for major osseous defect if present (731.3)
    - 996.46 wear articular bearing surface
    - 996.47 prosthetic failure/other mechanical complication
- PLUS V43.6x code to define type of joint replaced

96



## ICD-9 DIAGNOSIS INFECTED STAGED

### Infected

- Stage One 996.66 Infection and inflammatory reaction due to internal joint prosthetic device, implant, and graft...due to internal joint prosthesis
  - **PLUS V43.6x** code to define type of joint replaced
- Aftercare and subsequent stages INCLUDING encounter for reinsertion of prosthesis **V54.82** aftercare following explantation of joint prosthesis
  - **PLUS V88.21** acquired absence of hip joint
  - Or V88.22 acquired absence of knee joint
  - Or V88.29 acquired absence of other joint

97

## ICD-10

- Osteoarthritis further subdivided for laterality and site
  - Separate diagnosis for bilateral hip, knee, CMC
  - New code for post-traumatic osteoarthritis in addition to secondary osteoarthritis and traumatic arthritis
- AVN expanded to include more sites, laterality and cause M87.-
- Aftercare codes remain and further subdivided for laterality Z47.1 plus Z96.6-
- Explantation status and aftercare codes continue
  - Explantation Aftercare and reinsertion Z47.3-
    - 5<sup>th</sup> character specifies joint (shoulder, hip, knee)
    - No laterality
  - Acquired absence of joint following explantation w/ or w/o spacer Z89.- laterality and joint specific (shoulder, hip, knee)

98



99

**THANK YOU**



100

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101