Coding for Multiple Metatarsal Fractures, Bunionectomy with Exostectomy

Here’s some advice for their appropriate billing.

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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]

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.

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...
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 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-arthritis 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 fracture 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.
Fractures (from page 54)

of the hallux base, same site as the bunionectomy perfor-

mance, 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 remod-

ing of the base of the proximal phalanx? No, because it

was performed through the same incision, but because

bunionectomy procedures are “global packages” that in-

clude 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.

If you felt that in your case there was excessive work
done (and documented) “above and beyond” that 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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