Codingline Q & A

These queries and responses recently appeared on Codingline.

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.

Q: *"I have a patient who fractured the tip of his left 4th distal phalanx about 3-4 weeks ago. The capital portion was displaced, tipped over laterally. In addition, there was a soft tissue mass that developed at the tip. The mass keeps getting infected superficially due to the pressure. If the fragment and soft tissue mass are excised, should I bill for both or is the mass excision incident to the fracture fragment excision?*

A: The CPT code that best describes what you did would be CPT 28124 (partial excision [craterization, saucerization, sequestrectomy, or diaphysectomy] bone [e.g., osteomyelitis or bossing]; phalanx of toe). Since the soft tissue mass—granulation tissue or granulation secondary to the trauma—is likely resulting from and is in the same surgical site as the fractured fragment, the soft tissue excision would be included in the allowance of the bone excision.

Q: *"I sometimes see patients from nursing homes at a local wound care center. If the patient comes from a skilled nursing home and I bill CPT 97597, I understand that Medicare is not responsible for payment; that I should bill the nursing home. However, in the last month or so when I bill the nursing home, the nursing home administrator responds by saying that the patient was not assigned to a skilled bed at the time of service. Most of these have been billed to the nursing home after Medicare has sent a take-back request for payment for these dates saying the opposite. What am I not understanding?"*

A: I don't think you are misunderstanding anything. It looks like you are caught between two entities pointing their fingers at each other. CPT 97597, selective debridement, is listed as a "therapy" (versus a "surgery"). As a result, it falls under the Consolidated Billing guidelines. CPT 97597 is "paid for" by Medicare Part A under reimbursement to the nursing home when a patient is assigned a skilled nursing facility (SNF) bed. Even though you performed this service at a wound care center, if the patient resides in a SNF at the time of service, you cannot bill your Medicare Part B contractor; you would attempt to seek payment from the nursing home. Be aware that unless you have a prior arrangement with the nursing home for reimbursement of Consolidated Billing services, you may only get a "thank you for your service… no, we are not obligated to pay you" response.

You need to resolve the status of the bed the patient was assigned on the day you performed the selective debridement service. Contact the nursing home business office, and have them pull the accounting/business records on the patient. If the patient was not in a skilled nursing facility bed at the time of service, get copies of those records and ask the head of the business office or administrator of the nursing home to write a short note to that effect. Send the copy of the patient's status and the note, along with a request for reconsideration and a letter of explanation to your Medicare Part B contractor.

If, however, the records show the patient was a skilled nursing facility patient at the time of your services, you have to sit down and let the nursing home administrator know, and see if you can get them to retroactively reimburse you for your services, given the confusion. It might be a long shot, but you never know.

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Q: *"A Medicare patient presented with gout symptoms in the foot. I gave an injection of lidocaine, Marcaine, and a small amount of dexamethasone proximal to the gout-symptomatic area for the hyperemic effect. How can I bill the injection?"*

A: Your question notes that the injection occurred in the foot, but not the specific structure. The choice of injection coding would be based primarily on the location of the injection. For example, here are some options:

CPT 20550 Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")

CPT 20551 Injection(s); single tendon origin/insertion

CPT 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (toes); without ultrasound guidance

CPT 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (ankle); without ultrasound guidance

From your post, it sounds like you did not inject any joint, but injected a site proximal to the area of reported pain. While I understand injecting the site of an acute gout attack in the foot—typically a joint—with a local anesthetic and cortisone to reduce the inflammation secondary to hyperuricemia, I am not familiar with giving the injection to produce a hyperemic effect to an already inflamed and hyperemic site in the foot. Was the injection for inflammation/hyperemic relief or effect?

The reason I ask the question is that an auditor might ask the same question—it goes to medical necessity. If the answer is to reduce the impact of the acute gout attack by reducing/ temporarily eliminating the pain in the foot with local anesthetic and cortisone, then likely one of the codes listed above would be appropriate. Be sure to document and bill for the cortisone injectable given.

Q: *"How should I code for the repair of a left ruptured flexor hallucis longus tendon (which occurred just proximal to the sesamoids), including obtaining graft of extensor hallucis brevis tendon? Also, what would be the ICD-10 code(s) for the rupture?"*

A: The appropriate CPT code for the scenario described above is CPT 28202-LT (repair, tendon, flexor, foot; secondary with free graft, each tendon [includes obtaining graft]).

The ICD-10-CM coding would depend on the circumstance of the rupture. If the rupture was non-traumatic or spontaneous, the most appropriate ICD-10 code would be M66.372 (spontaneous rupture of flexor tendons, left ankle and foot). If the rupture was traumatic, the most appropriate ICD-10 code would be S96.012A (strain of muscle and tendon of long flexor muscle of toe at ankle and foot level, left foot; "A" = initial encounter or initial active [surgical] treatment).

Q: *"Our state Blue Cross/Blue Shield plan is now denying coverage of subtalar implants saying they are experimental. They did reimburse my billing of CPT 28725 (arthrodesis; subtalar), but denied the hospital for the implant. As a result, my hospital is now charging the patient the $3,000 implant fee. Any recommendations on how to resolve this?*

A: There are several issues present in your question. First, if you billed CPT 28725 (arthrodesis, subtalar) for the performance of a subtalar arthroereisis procedure, you billed for a procedure you did not do. The reason you were paid was that CPT 28725 would be included in the payer's software as a payable code—it is, after all, a fusion of a tarsal joint performed for degenerative changes and pain. If you are audited, instead of just being asked for money back, you may find yourself facing fraud (deliberate attempt to gain unwarranted reimbursement for services not performed) charges. Over the last 10 years, many articles and guidelines regarding the appropriate billing of a subtalar arthroereisis have been written. CPT 28725 or CPT 28725-52 is not one of them.

CPT Assistant (September 2011), in its "Frequently Asked Questions" section, had the following:

Q: *"What is the correct code to report for a subtalar arthroereisis procedure that includes insertion of a subtalar joint implant? Is it correct to report the procedure as a subtalar arthrodesis procedure (28725), a reduced service subtalar arthrodesis procedure (28725-52), or an open treatment of talotarsal joint dislocation (28585)?"*

There currently is no CPT code that specifically and accurately describes a subtalar arthroereisis procedure.

A: There currently is no CPT code that specifically and accurately describes a subtalar arthroereisis procedure. This procedure typically involves making an incision over the sinus tarsi and inserting an implant to reposition and stabilize the rearfoot, resulting in a decrease in pronatory forces to the foot. The intent and result is not fusion of the joint, so *a subtalar arthrodesis (28725) does not accurately describe what is actually performed.* Likewise, appending Modifier 52, Reduced Services, to the subtalar arthrodesis code would be inappropriate because the intent, performance, follow-up, and risks associated with the two procedures are wholly different. Recently, some surgeons advocated coding the subtalar arthroereisis procedure as a treatment of a dislocation. This would be a misrepresentation of the dislocation treatment codes, as there is no anatomical evidence of a joint dislocation (i.e., complete disruption of a joint) present at the subtalar joint when using this type of implant.

The most appropriate CPT code to report a subtalar arthroereisis procedure is code 28899, unlisted procedure,

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foot or toes. Alternatively, a temporary national HCPCS code (S2117) is defined as 'arthroereisis, subtalar'."

Since 2011, CPT did add the following Category III code, 0335T (extra-osseous subtalar joint implant for talotarsal stabilization) which, essentially, is a subtalar arthroereisis procedure. Category III codes are described as "temporary codes for emerging technology, services, and procedures. Category III codes allow data collection for these services/procedures...The inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety or the applicability to clinical practice." Category III codes, like temporary national HCPCS codes (e.g., S2117), are typically not reimbursable—which leads to issue #2.

Subtalar arthroereisis procedures have long been considered "experimental" in the eyes of many commercial payers—especially the Blues.

Subtalar arthroereisis procedures have long been considered "experimental" in the eyes of many commercial payers—especially the Blues. Before scheduling a subtalar arthroereisis procedure, you would be well advised to contact the payer, give them the code 0335T or S2117, and request written pre-authorization. This may be an uphill battle, so you might begin by gathering recent studies that support the indications, medical necessity, and standard of care for performing the procedure on your patient.

Back to your question. I recommend that you contact the Blue Cross/Blue Shield plan and let them know there was an error in coding the procedure performed. Ask them how you can refund the money paid you, and how you can send a corrected claim using the correct code for processing. Don't be surprised if 0335T or S2117 are denied reimbursement as investigational, experimental. Be sure to note the issue in your office compliance manual as well as your corrective action.

That leaves us with your patient who just got billed by the hospital for an implant; hopefully, not other related services—anesthesiologist, radiologist, pathologist, use of the operating room, supplies—directly and indirectly associated with the surgery. Not pre-authorizing this type of procedure leaves the patient having to pay significant amounts of money for something they were never told they might be at risk to pay. I'll close by saying: put yourself in your patient's position: What would you do if you started getting bills from providers that you thought or even were told when you signed your consent forms were going to be paid by your insurance plan, but were denied payment? Quietly accepting your fate probably isn't one of your considerations.

Codingline-NYSPMA 2018 "Foot & Ankle Coding Seminar"

Codingline's annual New York coding seminar will be held January 18, 2018 at the New York Marriott Marquis and will feature topics including updates in CPT, ICD-10, Medicare, DME for 2018; appropriate use of modifiers (especially modifiers "25" and "59"); coding for biopsies; Medicare data on podiatrist billing; "Legally Yours"; practice management and coding skin substitutes; routine foot care; and MIPS update—avoiding the penalty, the power of virtual groups, and questions from the attendees. Speakers include: Jeffrey Lehrman, DPM; David Freedman, DPM, CPC; Michael Warshaw, DPM, CPC; Larry Santi, DPM; Barry Block, DPM, JD; and Paul Kesselman, DPM. To register, go to https://www.expotracshows.com/podiatric/2018/codingline/.

Codingline 2018

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Good News: The APMA Coding Resource Center includes for its subscribers, for no additional charge, access to CodinglineSILVER through the CRC site. The feature will include an automatic registration and log on. The addition of CodinglineSILVER allows subscribers a "one-stop-shop" of coding resources and a means for asking coding, reimbursement, and practice management questions through the APMA Coding Resource Center. Subscribe to the CRC now—www.apmacodingrc.org.

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