Codingline Q & A

These queries and responses recently appeared on Codingline.

BY HARRY GOLDSMITH, DPM

Editor's Note: PM *mourns the untimely passing of* PM *Podiatry Hall of Fame inductee Harry Goldsmith, DPM. May his legacy of greatness inspire us all.*

Codingline will continue onward in its mission to enlighten the podiatric community about coding and reimbursement issues. Its ongoing existence is in itself a fitting tribute to Harry's memory.

Referred Fracture Care

Q: *If a patient is referred to us by an ER for a foot fracture, can we bill for fracture care? If they were put in a splint at the ER and sent to us the next day with their x-rays, what exactly can we bill for, just the office visit and a CAM walker?*

A: The emergency department physician in all likelihood is not providing fracture treatment (with all the follow-up defined in the treatment). Instead, the ED physician is evaluating the patient, making the diagnosis, perhaps dispensing crutches and instructions, and referring the patient to you for care. You should confirm the diagnosis and initiate a definitive treatment plan for the patient's fracture. Consequently, you should bill for the fracture care (most likely closed treatment with a 90-day global period assigned).

If this is a new patient to you, you would bill for an initial office encounter (level dependent on the findings, circumstances, management, and documentation). If this is an established patient, you would bill for an established office encounter (level dependent on the findings, circumstances, management, and documentation). In either case, be sure to add a "57" (decision for surgery) modifier to be paid for the fracture care ("major" procedure) and E/M service. When you bill for fracture care, any initial cast or splint application is included (when performed within the first 24 hours of the initiation of the fracture care).

Any medically necessary subsequence cast or splint applications are not included in the global allowance, and may be separately billed. Radiological studies, dispensing of DME (and supplies), and performance of therapy are not subject to the global inclusion. If these are medically necessary in the global period, they are separately reimbursable. To answer your question, yes, if medically necessary, you can bill for a CAM boot walker. You, however, cannot bill for global period E/M services related to the fracture since they are included in the fracture care global period and not separately reimbursed.

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Two Procedures, One Toe

Q: *I performed surgery to remove a cyst from the 2nd toe, right foot. I also did a distal interphalangeal joint arthroplasty on the same toe. The insurance company denied the soft tissue mass excision as they said it was bundled in the hammertoe repair allowance. The op report lists diagnoses and procedures as such: Diagnoses: 1. Right 2nd hammertoe. 2. Right 2nd toe soft tissue mass. Procedures performed: 1. Right 2nd toe arthroplasty. 2. Right 2nd toe soft tissue mass excision. Are these two distinct diagnoses and procedures indeed "bundled", or should I appeal?*

A: You did not mention where the soft tissue mass was present in relationship to the hammertoe correction (we'll assume by "arthroplasty" you are referring to bone and soft tissue work performed at the distal interphalangeal joint). If the "cyst" was incidentally present when you made your approach for the hammertoe correction or you decided after excising the "cyst" to also do a head resection of the middle phalanx, the coding would be limited to CPT 28285 (correction of hammertoe).

Things get dicier when the soft tissue mass excision and the hammertoe correction are located at distinctly different anatomic sites (proximal interphalangeal joint and distal interphalangeal joint) of the same toe. Many payers consider performance of CPT 28285 to be the "maximum" allowance regardless of the number of similar or lesser procedures performed on the same toe. For example, if a middle phalanx head and a proximal head resection were both performed on a single toe with or without soft tissue work, CPT 28285 x 1 would be all that would be reimbursed. Why? CPT 28285 is defined as "correction,

Continued on page 36

Q & A (from page 35)

hammertoe"—in other words, whatever it takes to make a contracted toe straight, even if it means both interphalangeal joints are worked on, fusion is performed, and tendons at the toe level are released, lengthened, transferred, or partially resected.

When a claim is received with two procedures, example, CPT 28285 and CPT 28092 (cyst excision, toe) identified as being on the same toe even with a "59" modifier applied to CPT 28092, payer software frequently denies the secondary procedure, leaving it up to the practice to appeal with a letter of explanation or writing off the balance. Many times on appeal, another denial is received. Why? It is based on the payer's determination that the clinical circumstances did not justify the use of the "59" modifier. Many billers familiar with the NCCI edits will note that CPT 28285 and CPT 28092 procedures, for example, when billed together, have a "1" indicator assigned the pair in the CCI edits, and that should allow the use of the "59" modifier on CPT 28092. Unfortunately, the "1" indicator does not guarantee unbundling and separate payments. The "1" indicator definition only allows unbundling of the two procedures "when appropriate". Who ultimately determines when it is appropriate? The payers, of course.

It is suggested that if the two procedures performed are completely independent of one another—i.e., distinctly different anatomical sites on the same toe—and you feel strongly that you should be paid for both procedures, you should submit a detailed op report evidencing the distinct locations and uniqueness of the mass, as well as the path report and a letter of explanation. If you took photos, be sure to include them. Despite your best efforts, you should be prepared for a denial.

Up-coding?

Q: *I performed a Green-Watermann procedure and billed CPT 28299 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with double osteotomy, any method). I also performed a tailor's bunionectomy on the same foot with no osteotomy—just removed the lateral prominence—and billed CPT 28122 (partial excision bone [e.g., osteomyelitis or bossing]; tarsal or metatarsal bone, except talus or calcaneus). Are these codes okay to use? I had someone tell me that I am up-coding. Am I really up-coding?*

A: The Green-Watermann bunionectomy is a distal metatarsal head osteotomy, CPT 28296 (correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method). It is not a "double osteotomy" procedure in the coding sense. Typically, the Green-Watermann procedure is performed to treat hallux limitus. So, the first question is, was the first ray procedure performed to repair a bunion, hallux limitus, or both?

There are three possible coding scenarios, depending on what was present and what you actually did:

1) If all you did was a Green-Watermann-type osteotomy to decompress the 1st ray and reposition the first metatarsal head, the appropriate code would be CPT 28306 (osteotomy, with or without lengthening, shortening, or angular correction, metatarsal; first metatarsal).

2) If, instead, you performed a hallux limitus correction (cheilectomy) at the metatarsal-phalangeal joint and a separate osteotomy on the metatarsal proximal to the 1st metatarsal-phalangeal remodeling, consider CPT 28306, CPT 28289-59. or

3) If the patient had a prominent 1st metatarsal head medially (and/or dorsally), you might want to think about coding the "bunionectomy" with osteotomy, CPT 28296. This would include the osteotomy as well as the removal of hypertrophied bone from both the metatarsal head and base of the proximal phalanx.

As for the removal of the lateral prominence of the 5th metatarsal, the most appropriate code is CPT 28110 (ostectomy, partial excision, fifth metatarsal head [bunionette] [separate procedure]), not CPT 28122.

One of the primary rules for selecting CPT codes is to pick the most specific code(s), when they exist in CPT, based on the work you performed.

In case you were wondering, there are relatively new "bunionette" diagnoses codes in ICD-10 for you to use: M21.621 (bunionette of right foot) and/or M21.622 (bunionette of left foot). These should be supplemented with symptom ICD-10 codes.

CPT 27640 Denial

Q: *I recently had a denial for CPT 27640 (partial excision [crateriza-tion, saucerization, or diaphysectomy] bone [e.g., osteomyelitis]; tibia). The denial remark code said, 'denied when performed by this type of provider'. Any suggestions on how to appeal this denial?*

Essentially, CPT 27640 is limited to cases of osteomyelitis.

A: There was no mention of what state you practice in. And there was no mention where on the tibia the surgery was performed. There is a lot of bone present between the ankle (distal tibial/medial malleolus) and the tibial tubercle. Presuming your state practice act includes that portion of the tibia you operated on, you should send a detailed operative report, a copy of your scope of practice, as well as a letter of explanation stating your case that you properly—within your scope of practice—performed surgery on your patient, that it was appropriate for a podiatrist in [your state] to perform this type of surgery. If, by the way, the payer denials your appeal, ignoring your argument, enlist both your state board and state podiatric medical association to assist you in going to the next level of appeal.

On another point, from a coding standpoint. Several years ago, CPT revised its description of CPT 27640 eliminating the option of "bossing" (unlike the foot section equivalent, CPT 28122, which still includes "bossing") as reason for performing the par-

Continued on page 37

Q & A *(from page 36)*

tial ostectomy of the tibia. Essentially, CPT 27640 is limited to cases of osteomyelitis. You might wish not only to validate your state scope of practice (that essentially you are licensed to perform work at the level of the tibia you are billing) with a copy of your practice act, but also submit a corrected claim billing CPT 27635 (excision or curettage of bone cyst or benign tumor, tibia or fibula) instead of CPT 27640.

Codingline 2018

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Dr. Goldsmith was Editor of Codingline.com and a recipient of the *PM* Lifetime Achievement Award. He passed away on Feb 7th after a courageous battle with lymphoma.