CODING Q&A

Fracture Care, Laceration Kits, Reimbursement for Extended Hours

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Q. When is it appropriate to use fracture codes without manipulation? If a patient comes in with pain in a finger after a fall and an E/M is performed, x-rays are taken to confirm a fracture, the finger is splinted and the patient is referred to an orthopedist, would that treatment constitute billing for initial care? If not, what must we do to be able to bill these?

A. CPT suggests that only the physician who provides the "restorative treatment" should code and bill for the fracture care.

CPT further states that "if cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., 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 [99070] in addition to an evaluation and management code as appropriate."

In your example, billing the E/M with modifier -25 (as long as the documentation is separate and identifiable from the procedure note), splint application (CPT 29130), x-ray, and supplies (HCPCS Q4049) used to make the splint would be appropriate because you do not plan any further treatment of the fracture. ■

Q. What code is used to bill for use of a laceration repair kit?

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A. HCPCS code A4550, "Surgical trays," can be used for a wound repair kit. Keep in mind that if you are billing a wound repair code (CPT 12001-13160), per CPT guidelines, the supplies will be included in the repair code. If the items in the kit are considered "over and above" those usually included for use in wound repair, you could possibly bill HCPCS code A4550 in addition to the wound repair code. You need to be sure you can justify that the contents in the kit are truly "over and above" those you would normally use to repair a laceration and be prepared to prove it in case of an inquiry from the insurance company. ■

Q. Our provider performed a simple I&D (incision and drainage) and the patient was also given 1 g of Rocephin intramuscularly (IM). We billed the E/M code with modifier -25, along with CPT codes 10060, "Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single, 96372, "Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular" with modifier -59 and J0696, "Injection, ceftriaxone sodium, per 250 mg." The payor bundled 96372, stating it is included with the payment of another procedure. How would you code this?

A. According to the National Correct Coding Edits, you have used modifier -59 appropriately to designate the IM injection was a distinct procedural service.

Review the payor rules to see if there is any bundling language included. If there is no rule stating that those codes will be bundled when billed together, consider submitting a letter of appeal for reconsideration of payment for the claim by the payor. If you find language in your payor agreement that supports the payment of the claim using appropriate

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modifier(s), be sure to include that information with your letter of appeal.

In this particular case, it might be helpful to include the CPT description of modifier -59 along with your supporting documentation detailing that the bundled procedure was not merely incidental, but was a distinct procedural service. If you are not sure of the appeals process, contact the payor for specific appeal instructions.

Many major payors, however, have made the decision that all IM injection codes are bundled into an E/M code (if coded), and are not separately billable on visits that also include an E/M code.

Worse yet, many payors have this policy but have not included it in their contract terms nor have they documented it in their provider manuals. ■

Q. Is the reimbursement different if an urgent care center is open from 8:00 a.m. to 11:00 p.m. versus 12:00 p.m. to 8:00 p.m.?

A. CPT code 99051 can be used when you provide services "during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service." Evening hours are generally considered to start at 5 p.m. regardless of a clinic's hours of operation. This code was designed to compensate your practice for the additional costs of being open extended hours.

Not all payors will reimburse for this code. Medicare does not reimburse for this code so do not bill it to them. However, some payors recognize the value and cost of these services and will reimburse for this code. Check the policies of each of your payors to see if you can receive compensation from them.

If the payor denies the code, you may be able to make this a point of negotiation when renegotiating a contract to get the payor to consider reimbursement for it. ■