CODING Q&A

Fracture Codes, Strapping and Splint Application Codes, S9088 Code

DAVID STERN, MD, CPC

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 evaluation and management 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 fracture 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 (E/M) code as appropriate."

In your example, billing the E/M (if appropriate) with modifier -25 (with a separate and identifiable 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.

However, if you splinted the fracture (i.e., provided "restorative treatment") and scheduled follow up at your facility, then it would be appropriate to code 26720, "Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each" or 26725, "...with manipulation, with or without skin or skeletal traction, each" along with the E/M (if appropriate), with modifier -57. ■

David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

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Q. We had a patient who came in with a wrist injury. The final diagnosis was a sprained wrist. We applied a cock-up splint (HCPCS code L3908) with an Ace bandage. Can we bill out a strapping code and a splint application code together? Can we bill for both the splint and the Ace bandage?

A. You would not bill splint or cast application codes with strapping codes for the same procedure. Billing for the splint application depends on whether the splint applied was prefabricated or was constructed in the clinic. The American Medical Association (AMA) stated in *CPT Assistant* (May 09:8) that "splint application requires creation of the splint."

According to HCPCS, L3908 is defined as "Wrist-hand orthotic (WHO), wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment." Therefore, billing a splint application code along with this code would not be appropriate because the fitting and adjustment is included with the code. If an elastic bandage was used to secure the splint, you would bill a HCPCS code from range A6448-A6450, depending on the size of the bandage.

"Medicare does not recognize either S9088 or 99051 so do not use either code for claims submitted to Medicare."

You can find splint and cast supply codes in HCPCS under code range Q4001-Q4051. If you use supplies to make your splints and casts, refer to these codes for billing. There are separate codes for different anatomy, plaster, fiberglass, and age.

For example, if a short arm splint was made in the clinic from fiberglass materials for an 8-year-old, you would use HCPCS code Q4024, "Cast supplies, short arm splint, pediatric (0-10 years), fiberglass." If the same splint was made for a 25-year-old, you would use code Q4022, "Cast supplies, short arm splint, adult (11 years +), fiberglass."

In both cases, you would also assign CPT code 29125, "Application of short arm splint (forearm to hand); static" because the codes for application and strapping are not age-dependent. ■

Q. Can we bill both the S9088 and 99051 on the same visit for our urgent care visits?

A. Yes, you can bill both codes for the same visit along with the E/M code. HCPCS code S9088, "Services provided in an urgent care center (list in addition to code for service)," is specifically for use in an urgent care center.

CPT code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service" is another code that could be billed to insurance plans, with the exception of Medicare. Evening hours are generally considered to start at 5 p.m. This code was designed to compensate your practice for the additional costs of being open for extended hours. This code is typically billed to patients seen after 5 p.m. Monday through Friday and all day on Saturday, Sunday, and federal holidays.

Medicare does not recognize either code so do not use either code for claims submitted to Medicare.

Check the policies of each payor for both of these codes to see if the payor views either code as a covered service. If not, you can consider requesting reimbursement for these codes when negotiating contracts. ■

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