Cast Changes During the Global Period

July 30, 2015

Question:
We have not been billing for cast changes during the global period, but have recently been told we should be reporting this service. In our orthopedic physician practice, on occasion a patient will require a cast change (for various reasons). If the physician orders the cast change and is present in the office during the cast change by our cast technician, can we bill Medicare during the 90-day global period?

Answer:
Thanks for your specific question and recognition that Incident-To rules apply in your scenario. Yes, if the physician orders the cast re-application and is in the office while the technician applies the cast, the service is billable to Medicare. Append modifier 58 to the cast application code since the patient is in a global period. Supplies are also reportable assuming the practice incurs the expense.

New or Established Patient Visit?

July 16, 2015

Question:
If a patient presents as a new patient visit and the surgeon reports an injection only, can the surgeon report a new
patient visit when the patient returns for the follow up visit?

Answer:
No, the surgeon had a face-to-face encounter with the patient to perform the injection; thus, the follow up visit within the three year period is an established patient visit.

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**CPT or HCPCS Tool?**

**July 2, 2015**

**Question:**
We have recruited a new hand surgeon and she frequently applies aluminum finger splints which are molded by the surgeon or her medical assistant. Can we report CPT code 29130 for the application and molding of this splint?

**Answer:**
Thanks for this great question! The application of the splint code 29130 is not reportable for an off the shelf product such as the aluminum splint. Report the appropriate HCPCS code for the supply only.

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**Medicare Incident-To Billing Rules**

**June 11, 2015**

**Question:**
We have a new PA in our office and we want to make sure we are billing correctly when we bill for his services Incident-To the physician. Am I correct to assume that when a new Medicare patient is seen in our office that the physician has to see the patient, examine the patient, and develop the plan of care him or her, and, on the next visit, the PA can implement the plan of care and bill Incident-To assuming the physician or another supervising physician is in the office?

Answer:
Yes, to report services Incident-To (meaning implementing the plan of care and physician in the office), the physician must independently obtain the History of Present Illness, must independently perform the exam, and all the decision making components including ordering and reviewing of tests, making the diagnosis and determining the plan of care. Assuming the physician performs this work, the PA may implement (not change) the plan of care and report services Incident-To the physician if the physician or another supervising physician is in the office.
Incident-To services do not apply to the first visit for a new patient, established patient with a new problem, a visit where the PA changes the plan of care or when a physician is not in the office. Incident-To services also do not apply in the hospital setting.

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**Injection Code 96372, Is This Correct?**

May 21, 2015

Question:
I am new to orthopaedic coding, having just left a Family
Practice group after many years. The surgeon said he did an injection to the flexor tendon sheath of the right index finger. I want to verify that CPT code 96372 is correct for the injection. I am very familiar with reporting the J codes for the drugs.

**Answer:**
Welcome to the world of Orthopaedic Coding! Your question is one that we receive on occasion when someone like yourself has taken the huge leap from the world of a medical practice into surgical coding. You will now want to familiarize yourself with the musculoskeletal section of the CPT book.

In the musculoskeletal section, find the section titled Introduction or Removal (20500-20697). You will see a list of codes beginning with CPT code 20500 through 20612 which will cover the majority of injections performed in a general orthopaedic practice. You state the injection was given to the flexor tendon sheath, thus the correct code will be 20550, Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”). Kudos to the surgeon for the great documentation of exactly where the injection was administered. The appropriate J code may be reported in addition to CPT code 20550, as you are familiar with doing.

You may find it beneficial to set up a contract with KZA and work with Mary LeGrand on any of your coding or practice management needs. This relationship can be developed remotely and allow you access to Mary for any coding questions, assistance with operative notes, appeals, or audits. You may also consider attending an AAOS sponsored coding course.
E&M Selection Based on Time

May 7, 2015

Question:
Our surgeon saw a patient in the office following a shoulder MRI. In the visit, the surgeon documented, “I had a very long face-to-face discussion with the patient today regarding their shoulder MRI. I spent over 20 minutes in the exam room discussing the results of the scan, reviewing the MRI with the patient, discussing the findings, pathology of the disease process and discussing operative versus non operative management. The patient has chosen to start first with physical therapy but understands that due to the pathology at this time, surgery may be required in the future.” The surgeon has stated that this visit should be based on time because there was no medical necessity to repeat all the history and exam information as nothing had changed since the prior visit. In looking at the note, I do not believe the documentation requirements are met to select a code based on time. Can you please advise?

Answer:
Thanks for reaching out. Your question is a great question and the scenario an excellent one to educate the surgeon on closing the documentation gaps required when counseling and coordination are the exceptions to selecting a code based on the three key components. To report a service based on time, three key elements must be documented: 1) the total face-to-face time between the surgeon and, in this case, and the patient. It is not the time the patient is in the office, but the total face-to-face time only. 2) that greater than 50% of the time (or the specific amount of time equaling a unit greater than 50%) was spent counseling or coordinating care and 3) the nature of the discussion or work must be documented. In your scenario, two of the three elements are present, but what is missing is the statement related to the
amount of the face-to-face time that was spent with the patient. Without all three elements, the code selection reverts to the three key components.

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**Resident Services**

April 23, 2015

**Question:**
We are in an academic setting and I have a question about a specific service performed when a resident was involved on a Medicare case. I was reading notes for a patient who presented to the emergency room (ER) and was admitted to the Orthopaedic Attending physician’s service. The notes by the resident in the ER indicate that the Attending Physician was contacted, though the Attending did not see the patient in the ER. The resident documented the findings and discussion with the attending via the telephone; documented specific orders by the Attending for care provided while the patient was in the ER, including the admission to the Orthopaedic Service. The Attending Physician saw the patient the next day and documented the visit. My question is, can I bill for an E&M service for the telephone discussion with the Attending Physician even though the Attending did not see the patient in the ER? The Attending Physician stated that unless something has changed, the discussion with the resident is not a billable service for him.

**Answer:**
Your physician is correct. First, there have been no changes in Medicare’s Teaching Physician or any billing rules that would allow the physician to report an E&M service when there was no face-to-face service. While the resident appropriately discussed the case with the Attending Physician, there are no
services reportable by the Orthopaedic Attending Physician. Your physician will report the initial hospital care codes for the first encounter the following morning. Because the provider is Medicare, you will also append the AI modifier on the appropriate E&M code to indicate that the Orthopaedic Attending Surgeon is the admitting physician. This modifier will be placed in the second modifier field if a more appropriate payment modifier (e.g., decision for surgery modifier) is required.

Claw Toe

April 9, 2015

Question:
We are having some debate about whether CPT code 28285 (hammertoe repair) would be appropriate for fusion of a claw toe? The claw toe is the DIP joint; the hammertoe is the PIP joint. However, code 28285 does not specify which interphalangeal joint is corrected. Should we report 28285 or an unlisted code?

Answer:
A: Thanks for your inquiry. As you note, CPT does not specifically state which joint; it says “e.g., interphalangeal fusion.” The “e.g.” directs us that this is only an example. Therefore, CPT code 28285 is the correct code, assuming the documentation supports the work described by 28285. You will note in Code-X that the claw foot and claw toe diagnosis codes support the medical necessity to report CPT code 28285.
**Suture Removal**

March 26, 2015

**Question:**
Our surgeon saw a patient in the ER for a fracture and reported the global fracture code. The ER physician had repaired a separate wound laceration at a different site prior to our surgeon arriving in the ER. The patient is now being seen in the office and the surgeon evaluated the wound area, and removed the sutures. Is this reportable? If yes, what CPT code would I use?

**Answer:**
Thanks for your inquiry. There is no CPT code for suture removal in the office, and the work associated with removing the sutures is inclusive to any reportable E&M service performed on the same day. In your example, the patient is in a global period for the fracture, thus E&M work associated with the fracture is not reportable. An E&M for evaluation of the separate stand-alone wound is reportable if medical necessity is present. As the patient is in a global period, the surgeon will append modifier 24 (unrelated E&M during the global) to the established patient visit code and link the diagnosis to the wound.

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**Bone Marrow Aspirate for Grafting**

March 12, 2015

**Question:**
Our surgeon performed a bone marrow aspirate from the iliac crest when performing a spinal fusion. The surgeon gave me CPT code 38230, but I am wondering if this is correct. Can you illuminate this for me?

**Answer:**
While the aspiration of bone marrow is separately reportable, CPT code 38230 is not the correct code. This code describes the aspiration of bone marrow for transplantation, such as in a bone marrow transplant in an immunosuppressed patient. The correct code, when the aspirate is harvested from a separate surgical site via a separate incision for the intent of a fusion is CPT code 38220, Bone marrow; aspiration only. Append modifier 59 to indicate current procedure service.