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BY AAPC

Internal Medicine Coding Alert

CPT® Coding: Know the Who, What, and Where of Strapping and Splinting to Boost Your Claims

And you can wrap things up with a supply code, too.

When a patient visits your physician requiring a strap or a splint, you will need to know how to distinguish between the two procedures by garnering the right information from patient documentation.

Use these three pointers to help guide you through coding for splinting and strapping.

1. Who Performed the Procedure?

When your clinician determines the need for placement of splints or straps, you should first see if your clinician placed the splint or strap because this affects your code selection.

Why: You'll only report a splinting or strapping code if your clinician applied the splint or strap.

If your clinician was not directly involved in the placement of the splint or strap, you can't report a splinting or strapping code for the work performed by your physician. "Procedures cannot be billed 'incident to,'" says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, senior principal of ACE Med, a medical auditing, coding and education organization in Pittsburgh, Pa. However, "if the tech is under direct supervision (the physician is present), there might be the ability to report this."

"Medicare does not allow incident to, but other payers may follow AMA which states it is fine," says **Mary I. Falbo, MBA, CPC,** CEO of Millennium Healthcare Consulting, Inc. in Lansdale, PA. Check with third party payers, she advises.

Best bet: Report your clinician's work to evaluate the patient and determine the need for a splint or strap with the most appropriate evaluation and management (E/M) code for the encounter.

If your clinician performed an E/M and the splinting or strapping, you may be able to report an E/M code in addition to the splinting or strapping code. If you report an additional E/M code for the encounter, you should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code you report for the encounter.

"Correct Coding Initiative (CCI) edits bundle E/M codes into splinting and strapping codes," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "However, the CCI edits permit the bundle to be overridden with an appropriate modifier, such as modifier 25. Since the E/M code is typically the column 2 code in these edits, the modifier should be appended to the E/M code."

2. What Was Done?

Once you have identified the extent of your physician's involvement, you need to know whether your clinician performed splinting or strapping to report the appropriate code for the encounter. You need to know how to glean this information from patient notes if your clinician has not directly mentioned what procedure he performed.

"The documentation should illustrate what was done," Hauptman says. "If there is no documentation, then you wouldn't be able to report anything. You could ask the physician to update his documentation if the service was recently performed and it is fresh information."

"If the physician hasn't mentioned it, you need to check what he/she has documented in the patient's note," Falbo adds.

For strapping, your clinician will use adhesive tape in an overlapping fashion to provide support or restriction of movement of ligament structures by exerting pressure upon the extremity or other area of the body. It also helps in compression of a body part.

While strapping involves use of adhesive tapes or bandages, splinting involves your clinician using a stiffer material such as metal, wood, plaster, or plastic. Your clinician might opt for splints when the patient has had an injury such as a sprain, fracture, or dislocation, and the splint will help provide stability and protection.

3. Where on the Patient's Body Was It Performed?

After you have determined whether your clinician performed a splinting or strapping, you next should look through patient notes to check the anatomical location where your clinician applied the immobilization.

You have two different code sets based on anatomical location to report splinting and two more sets based on anatomical location to report strapping. So, based on anatomical area of involvement, you have one code set for splinting and strapping of body and upper extremities and another for lower extremities. Choose from 29105-29131 when your clinician performs splint application for body and upper extremities or from 29505-29515 for splinting of lower extremities.

Similarly, you choose from 29200-29280 for strapping of body and upper extremities while you select from 29520-29584 for strapping of lower extremities.

Example 1: Your clinician reviews an established patient who complained of pain in the ankle of the right foot that began when she twisted her foot and fell while having a shower. Your physician performs a level two E/M service and diagnoses the patient with a sprained ankle. Your clinician then applies an ACE bandage that covers the sprained ankle.

What to report: You need to report a strapping code for the encounter since your clinician applied the ACE bandage, which is used for strapping. You must report the following codes for the encounter:

- 29540 (Strapping; ankle and/or foot);
- S93.401A (Sprain of unspecified ligament of right ankle, initial encounter) for the diagnosis code to support the claim for strapping;
- W18.2XXA (Fall in [into] shower or empty bathtub, initial encounter) attached to the strapping code to show the cause for the injury;
- 99212 (Office or other outpatient visit for the evaluation and management of an established patient...) for the level two E/M service. Append modifier 25 to the E/M code; and
- 99070 (Supplies and materials [except spectacles], provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) or A6448 (Light compression bandage, elastic, knitted/woven, width less than 3 inches, per yard) for the strap, depending on payer preference for supply coding.

Example 2: In the example illustrated above, if your clinician opts to place a splint instead of the ACE bandage, you will report a splinting code instead of the strapping code. Likewise, you will change your supply code with an appropriate splinting supply code. So, you report the following codes for the encounter:

- 29515 (Application of short leg splint [calf to foot]);
- S93.401A as the diagnosis code to support the splinting code;
- W18.2XXA linked to the splinting code to show the cause for injury;
- 99212-25 to report the level two E/M service; and
- 99070 or A4570 (Splint) for the splint, depending on payer preference for supply coding.

"As noted, whether you report a separate code for supplies and what code you report if you do may depend on payer preferences," Moore notes. "Some payers may consider the supplies to be covered by the payment for the strapping or splinting code. CPT® guidelines preceding the strapping and splinting codes indicate that it is appropriate to use code 99070 when splint application or strapping is provided as an initial service (e.g., casting of a sprained ankle) 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 the individual rendering the initial care only."