Internal Medicine Coding Alert

Reader Question: Fracture Care

Question: One of our patients whom we follow regularly for diabetes and hypertension complained of pain in her finger after a fall. We x-rayed her finger and discovered that she had a fracture. We reduced her fracture in the office and placed the finger in a splint. We are thinking of billing the surgical code 26725 for the reduction, along with 29130. Is this correct?

New York Subscriber

Answer: Assuming that you will not be referring the patient to an orthopedist for follow-up of her fracture, you could bill 26725 (closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each) for the patients fracture care, but you would not be able to bill for the placement of the splint. Depending on the circumstances, you may be able to bill an office visit.

To understand the coding rationale for this case, you must first know what is included in fracture care code 26725. Closed treatment of a fracture is non-operative treatment. This type of treatment can be rendered in a physicians office and is normally reserved for simple fractures. Manipulation of a fracture is also known as a reduction or setting of the fracture by the application of manually applied forces. CPT refers to splinting or strapping as skin traction the application of a force to a limb using felt or strapping applied directly to the skin only.

Code 26725 states with or without skin traction. By definition, application of the splint is included in the code. This is confirmed in the instructional notes located under the Application of Casts and Strapping (29000-29799) codes. Remember that only the initial cast, splint or strapping is included in the fracture care code. If you need to replace the patients splint at a subsequent visit, you could bill 29130 (application of finger splint; static) for the replacement splint.

Further, fracture care codes are surgical codes and thus subject to the global surgical package. The global surgical package includes the manipulation of the fracture, the preoperative visit, and 90 days of uncomplicated follow-up care. If there is sufficient documentation, the preoperative visit may be billed separately with modifier -57 (decision for surgery).

To bill for an E/M visit, you must document all elements including medical decision-making. If the only documentation in the medical record is a notation of a fracture along with documentation of the reduction and splinting, then a visit should not be billed.

Because many internal medicine patients are seen for several chronic medical conditions, it is likely that the physician will need to see a patient for those conditions during the 90-day fracture care global period. Append modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) to these E/M visits to prevent them from being denied as part of the global surgical package. Be certain that you use the same diagnosis code for these visits.