# Part B Insider (Multispecialty) Coding Alert

## ORTHOPEDIC CODING QUIZ: 5 Questions Lead You to Orthopedic Coding Success

**This quick quiz will show you where your orthopedic coding and billing skills fall.**

Want to stay polished on your bone and joint coding and billing skills to ensure stellar pay and compliance? Give this quiz a whirl, and then check your responses against our answers.

**Questions:**

1. The physician uses your practice's x-ray equipment to place the needle prior to a hip injection. He did not use the C-arm or any other fluoroscopy device for additional guidance. Should you include modifier 26 on the claim?

2. The physician arthroscopically repairs a rotator cuff on the left shoulder, and then aspirates the right shoulder. You use the LT and RT modifiers to indicate that the doctor worked on different sites, but the insurer denies the claim anyway. How can you get reimbursement for the two separate procedures?

3. What are the keys to deciding when to report splinting and when to report strapping?

4. Can you report debridement if the physician documents no gross contamination? For instance, the physician reduces an open tibia fracture, applies an external fixator, and performs irrigation and debridement.

5. A patient sustains a whiplash injury in a road traffic accident. Your physician performs trigger point injections in four sites. You report 20552x2 (because the descriptor for 20552 states "one or two muscle[s]") but you are denied payment for the second code. What went wrong?

**Answers:**

1) If your office owns the guidance equipment, you shouldn't append modifier 26 (Professional component) to the guidance code. Report the X-ray with 73500 (Radiologic examination, hip, unilateral; 1 view) or 73510 (... complete, minimum 2 views), depending on the number of views. Include 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) for the injection itself. Remember, the physician must document an interpretation report to qualify for billing this way.

2) For these procedures, you can't stop with modifiers LT (Left side) and RT (Right side). You'll also need modifier 59 (Distinct procedural service). To report both the arthroscopy and aspiration, you should use 29827-LT (Arthroscopy, shoulder, surgical; with rotator cuff repair) and 20610-59-RT (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]).

Although the LT and RT modifiers indicate that your orthopedist treated different shoulders, modifier 59 definitively shows that the two procedures were separate in this case. Typically, 29827 includes the work associated with an aspiration. In this case, modifier 59 will help override the Correct Coding Initiative (CCI) edit that's probably triggering the denial, and the LT and RT modifiers will show that the procedures were performed on different shoulders.

3) If you master a few important differences between the two, you should be able to ace splinting and strapping coding, which CPT® lists in the 29000-29799 range (Application of casts and strapping).

**Strapping:** Strapping involves layers of tape, web roll and possibly an Ace bandage, according to clinical conventions. The patient retains some range of motion, but strapping's non-rigid materials do support the joint.

**Splinting:** Splinting once involved plaster and fiberglass. Now, off-the-shelf, pre-made plastic products are widely available. They're more rigid and provide greater support with less freedom and a smaller range of motion.

Potential pitfall: You can't report 29000-29799 to Medicare unless your physician applies the splint or strap. This is important, because occupational therapists (OT), physical therapists (PT), or nurses put on most of the off-the-shelf pre-made items. The physician must also provide the initial splint or strap, or replace it, and you can't report fracture care for the same injury if you want to report a 29000-29799 code.

4) The short answer is "Yes." Most payers should allow you to report the appropriate debridement code from the 11010-11012 series (Debridement including removal of foreign material  associated with open fracture[s] and/or dislocation[s] ...) as well as 27752 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; with manipulation, with or without skeletal traction).

When reporting codes 11010-11012, the surgeon must document that he removed devitalized tissue using a surgical instrument; simply irrigating out the fracture site does not qualify.

**Don't miss:** You may also report a code such as 20690 (Application of a uniplane [pins or wires in one plane], unilateral, external fixation system) to reflect the surgeon's work applying the external fixation device to the patient's leg.

5) You have made the correct choice of the applicable code set, but you just picked the wrong trigger-point injection code. While you should use 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]) for one or two shots, the correct choice for three or more shots is 20553 (... single or multiple trigger point[s], three or more muscle[s]).

So when you re-submit your claim, report 20553 for all four trigger point shots. Additionally, you should report ICD-9 codes 847.0 (Sprains and strains of other and unspecified parts of back; neck) and E812.0 (Other motor vehicle traffic accident involving collision with motor vehicle; driver of motor vehicle other than motorcycle) with 20553 to represent the patient's whiplash and the cause of the injury.