INGENIX®

Coding Companion for Primary Care

A comprehensive illustrated guide to coding and reimbursement

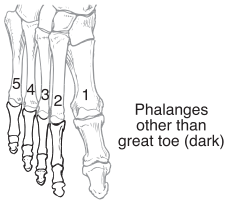
2009

Contents

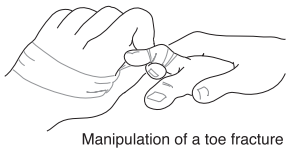
28510-28515

28510 Closed treatment of fracture, phalanx or phalanges, other than great toe; without manipulation, each

28515 with manipulation, each



Phalanges other than great toe (dark)



Manipulation of a toe fracture

A fracture of a phalanx or phalanges other than the great toe is treated in a closed fashion without manipulation. Report 28515 when manipulation is required to reduce the fracture

Explanation

The physician treats a fracture of one of the four toes other than the big toe without any open surgery and with or without manipulation of the bones. In 28510, separately reportable x-rays of the toe confirm a fracture or fractures of the bones where the fragments are in an acceptable position. The physician applies a splint, brace, or cast to the toe and foot. In 28515, separately reportable x-rays confirm a fracture or fractures of the toe with the bony pieces in unacceptable positions for correct healing. The physician pulls or pushes on the toe or foot in such a way as to restore the bones to their correct alignment. X-rays are taken to confirm the desired result. A splint, cast, or brace may be applied.

Coding Tips

These procedures may be reported multiple times as they are reported for each closed treatment of a phalangeal fracture performed. When 28510 or 28515 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. These codes report closed treatment of toe fractures other than the great toe. For closed treatment of fractures of the great toe, see 28490–28495. For radiology services, see 73620–73630, and 73660. Supplies used when providing this procedure may be reported with A4570. Check with the specific payer to determine coverage.

ICD-9-CM Procedural

79.08 Closed reduction of fracture of phalanges of foot without internal fixation

93.53 Application of other cast

93.54 Application of splint

Anesthesia

01462

ICD-9-CM Diagnostic

733.19 Pathologic fracture of other specified site

733.95 Stress fracture of other bone — (Use additional external cause code(s) to identify the cause of the stress fracture)

826.0 Closed fracture of one or more phalanges of foot

Terms To Know

cast. Rigid encasement or dressing molded to the body from a substance that hardens upon drying to hold a body part immobile during the healing period; a model or reproduction made from an impression or mold.

closed fracture. Break in a bone without a concomitant opening in the skin. A closed fracture is coded when the type of fracture is not specified.

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation, and with or without traction.

manipulation. Skillful treatment by hand to reduce fractures and dislocations, or provide therapy through forceful passive movement of a joint beyond its active limit of motion.

pathologic fracture. Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.

CCI Version 14.3

01470, 11719, 20550-20553, 29345-29358, 29405-29425, 29445-29450, 29505-29515, 29540-29715, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 90760, 90765, 90772, 90774, 90775, 97597-97598, 97602-97606

Also not with 28510: 11055-11057, 12001, G0127, G0168

Also not with 28515: 11056, J2001

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
28510	2.82	2.87	90	N/A
28515	3.49	3.78	90	N/A

Medicare References: None

0064T

0064T Spectroscopy, expired gas analysis (eg, nitric oxide/carbon dioxide test)

Explanation

Spectroscopy is used to measure energy absorbed from a narrow band of light wavelengths passing through an expired gas sample. This technique can be used to measure expired carbon dioxide (CO2) and nitrous oxide (N20) while under anesthesia. Spectroscopy also can be used to measure exhaled nitric oxide (NO) in patients with respiratory diseases. One of the newest uses involves laser spectroscopy of expired NO in asthma patients. Measuring fractional NO concentration in expired breath as an adjunct to other established clinical and laboratory assessments can be helpful in evaluating the patient's response to anti-inflammatory therapy.

0188T-0189T

0188T Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30- 74 minutes

0189T each additional 30 minutes (List separately in addition to code for primary service)

Explanation

The physician delivers direct medical care from an off-site location for a patient who is critically ill or critically injured. Using real-time interactive videoconferencing, this method of critical care is used in addition to on-site critical care services in situations where the patient requires more resources than are available on-site. The physician must have real-time access to the patient's medical record (medication record, nursing and progress notes, vital signs, laboratory and other diagnostic test results, and x-rays), as well as the ability to enter orders electronically, document the services provided, communicate by videoconference with on-site personnel, thoroughly assess the patient and equipment, and communicate with patients and family members on a real-time basis. Report 0188T for the first 30–74 minutes of remote real-time interactive video-conferenced critical care on a given date. This code should be reported only once per day, even though the time spent by the physician on that day may not be continuous. Report 0189T in conjunction with 0188T for each additional 30-minute period in excess of the first 74 minutes.

Coding Tips

These codes are new for 2009.

0194T

0194T Procalcitonin (PCT)

Explanation

Procalcitonin (PCT) is produced in the thyroid cells of healthy individuals as a precursor for the hormone calcitonin and is not normally found in human blood. However, bacterial infections may cause many of the body's organs to produce PCT, resulting in a rapid elevation of PCT blood levels. This increase is not caused by viral infections. PCT blood levels reflect the severity of bacterial infection, making it a useful biomarker in the diagnosis of bacterial infection and sepsis. Specimen is serum or plasma; test method is by various assays.

Coding Tips

This code is new for 2009.

70030

70030 Radiologic examination, eye, for detection of foreign body

Explanation

X-rays of the eyes are obtained to determine the location of a foreign body in the eye. After positioning the patient, either a one or two view x-ray is obtained. Transparent objects such as glass may not be good candidates for x-ray visualization. The physician supervises the procedure and interprets and reports the findings.

Coding Tips

Procedure 70030 has both a technical and professional component. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier.

70140-70150

70140 Radiologic examination, facial bones; less than 3 views

70150 complete, minimum of 3 views

Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, x-rays are taken of the facial bones. The physician supervises the procedure and interprets and reports the findings. When less than three facial x-rays are taken, report 70140. When more than three are taken, report 70150.

Coding Tips

Procedures 70140–70150 have both technical and professional components. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier.

70160

70160 Radiologic examination, nasal bones, complete, minimum of 3 views

Explanation

Films are taken of the nasal bones to include a complete exam, or minimum of three views. Typically, this exam would consist of both right and left lateral (side to side) for comparison, as well as a tangential projection in which the x-ray beam is directed from a position above the patient's head down through the nose. This view is primarily used to demonstrate the medial or lateral (side to side) displacement of nasal fractures.

Coding Tips

Procedure 70160 has both a technical and professional component. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier.

71010

71010 Radiologic examination, chest; single view, frontal

Explanation

A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

Coding Tips

Procedure 71010 has both a technical and professional component. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier. For concurrent computer-aided detection (CAD) see 0174T. Do not report 71010 with 0175T.

71020

71020 Radiologic examination, chest, 2 views, frontal and lateral;

Explanation

Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

Coding Tips

Procedure 71020 has both a technical and professional component. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier. For concurrent

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient and instructions and