Class 13 Homework:
Musculoskeletal Outpatient Services

1. Is it ever appropriate to assign a cast APPLICATION code (29000-29799) when you are also assigning a 20000 series fracture care code? The answer is NO - it is NEVER OK. But, if you are providing this service in your clinic and you use cast padding and fiberglass to build the cast or splint, it is OK to code the supplies to HCPCS codes. Of course, it is not OK to code supplies when you are working in the hospital because you did not buy the supplies.
    a. True
    b. False

2. A right Monteggia fracture dislocation is treated with open reduction internal fixation (ORIF). A splint is applied. Code the ICD-10-CM diagnosis code followed by the CPT procedure code(s). Leave only a space between codes.

3. An open Monteggia fracture with the typical dislocation of the radial head at the elbow; because of the type of injury there is a significant contaminated open wound over the fracture site. Extensive subcutaneous fracture site debridement is necessary. The fracture and dislocation are managed with open reduction internal fixation (ORIF) using a plate and screws. It was also necessary to apply a uniplane external fixation device. Wounds were closed, dressings applied, reduction and alignment validated by x-ray, then a posterior splint was applied. Assign appropriate CPT code(s) and any necessary modifiers.
    a. 24650 11010-51
    b. 11010-51 29105
    c. 24635 20690-51 11010-51
    d. 24635

Information from the hospital operative report:

Postoperative Diagnosis: Left, grade II open mid-shaft tibial and fibular fracture.

Procedures: Irrigation and debridement of the left open wound including muscle
Closed reduction of the tib/fib fractures and application of a unilateral, uniplane external fixation device and a long leg plaster splint.

1. What is/are the diagnosis code(s)?
2. What is/are the surgery code(s)? HINT: Report CPT procedure code with highest RVU first, follow with other codes and add appropriate modifiers.
3. Is/Are the code(s) bundled?
4. The wound was left open, and the patient was taken back to the OR in five days for final closure. What modifier will be indicated for the 5-day-later surgery:
    a. 78
    b. 79
    c. 76
    d. 58

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Hospital Operative Report

Preoperative Diagnosis: Fracture of fibula, left

Postoperative Diagnosis: Left distal fracture of fibula (lateral malleolus)

Procedure: Reduction of fibular fracture

Anesthesia: Spinal by CRNA Smith

A fourteen-year-old gymnast feels pain in her left leg after vaulting at practice. She is unable to bear any weight on her left leg.

Physical examination showed the foot and ankle to be normal. The neurovascular status of the foot was normal. The ankle was non-tender and not swollen. Findings were confined to the distal fibula, the lateral malleolus. There was point tenderness in this area. An x-ray of the tibia and fibula showed a displaced fracture of the distal fibula.

The fracture was reduced, and the patient placed in a short leg splint with extensive padding over the fracture site. Crutches were provided and she was instructed not to place any weight on the foot. She was given Tylenol #3 for the pain and instructed to follow-up with me in 10 days.

You are coding for the surgeon and CRNA Smith. Enter answers for the 12 questions below.

1. What is/are the diagnosis code(s)? (No external cause code)
2. What is/are the surgery code(s)?
3. How many follow-up days does it have?
4. What is/are the anesthesia code(s)?
5. Would you code the x-rays or crutches?
6. Would you code for the splint application?
7. What office visit code(s) will you assign when the patient returns to the office for follow-up?
8. If you are an FQHC/RHC, will you code a regular office visit when the patient comes into the office for follow-up?
9. During the follow-up period, will you code for x-rays and/or splint/cast application when the patient comes into the office for follow-up?
10. If the patient has a complication and your doctor (the surgeon in this case) treats the complication, will you code and bill E/M's or other services?
11. If the patient goes back to surgery for a complication, what modifier will you use on the 2nd surgery?
12. If you see the patient in the office two weeks after this fracture treatment and you treat him for strep throat, what modifier will you attach to the E/M on that day?

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Hospital Operative Report

Preoperative Diagnosis: Displaced Colles fracture, Left
Postoperative Diagnosis: Same
Procedure: Closed reduction, application of uniplane external fixator
Anesthesia: GET by Dr. Gasman
Clinical Note: The patient is an 86-year-old female who suffered a highly displaced, severely comminuted distal fracture of the radius and ulna. She comes for a closed reduction and application of unilateral external fixator.
Operative Note: The patient was brought to the OR. After general anesthesia was obtained, 1 gram of intravenous Kefzol given, her arm was prepped and draped and placed in strong traction. Closed reduction was performed. The reduction was confirmed with C-arm. At this point, using the stable lock external fixator, two proximal radial pins and two distal second metacarpal pins were placed. The fracture was held in fixation and the external fixating device was placed across the fracture. Confirmation AP and lateral projection showed acceptable reduction of the fracture considering that it was highly comminuted and very unstable in nature. The patient tolerated the procedure well and was transferred to the recovery room in good condition after dressing was applied.
You are coding for the surgeon. Answer the six questions below. Also report for Dr. Gasman.

1. What is the diagnosis?
2. Identify procedure code(s).
3. Which procedure code has the highest RVU?
4. Is/Are the code(s) bundled in CCI edits?
5. What is/are the anesthesia code(s)?
6. If this patient fell 30 days after this surgery and went to surgery for a torn medial meniscus, what modifier would be used on that knee surgery?

Hospital Operative Report

Preoperative Diagnosis: Internal derangement medial meniscus tear and degenerative changes
Postoperative Diagnosis: Same
Procedure: Arthroscopic debridement, partial medial meniscectomy
Anesthesia: General anesthesia by Dr. Gasman
Clinical Note: The patient is a 60-year-old male whom we have been following for some time with pre-arthritic/arthritic knee. We have treated him with anti-inflammatories, physical therapy, and injections of cortisone. None of these have helped and he continues to have significant knee effusion. He comes for an arthroscopic evaluation.
Procedure: The patient was brought to the OR and after general anesthesia was obtained and 2 grams IV Kefzol given, his knee was prepped and draped in a sterile fashion. The arthroscope was introduced in the lateral portal; after the medial inflow cannula was established, the diagnostic procedure began. The under surface of the kneecap had a significant plica region that was debrided. The femoral trochlea was much more damaged, with grade III-IV full-thickness loss of cartilage. It was debrided down to stable surfaces and the lateral joint line was viewed. He had some degenerative fraying of the lateral meniscus, and the lateral femoral

condyle and tibial plateau also had some grade I-II changes, but nothing significant. The medial side had a significant degenerative medial meniscus tear along with the grade II-III changes of the medial femoral condyle and tibial plateau. All surfaces were debrided down to stable cartilaginous borders. Partial medial meniscectomy was performed with mechanical and handled instruments. The knee was irrigated, and the wounds were closed with nylon. The patient tolerated the procedure well and was transferred to the recovery room in good condition after the knee was injected with Marcaine and Epinephrine.

You are coding for the surgeon. Answer the five questions below. Also report for Dr. Gasman.

1. What is/are the diagnosis code(s)?
2. What is/are the CPT(s) the coder would consider?
3. Is/Are the code(s) bundled in CCI edits?
4. What is/are the anesthesia code(s)?
5. How many follow-up days?