Commonly asked hand coding questions

By Mary LeGrand, RN, MA, CCS-P, CPC

Previous question-and-answer columns have addressed commonly asked questions about joint injections, foot and ankle services, and other issues. This issue focuses on questions about hand coding.

Collagenase injections

Q. How should we report services for initial and subsequent collagenase injections?

A. The answer depends on whether your Medicare carrier or private payer has a specific policy related to this procedure. Check their websites for medical policies or coding instructions.

In the absence of a specific payer policy, the 2011 recommendations are to report the services as follows:

For the day one injection:
- 992xx—If an Evaluation and Management (E&M) is the significant separate service
- 20550—Injection(s); single tendon sheath, or ligament, saphenous nerve
- J0775—Report number of units administered or wasted if entire vial is not administered.

For the day two E&M visit and finger extension (manipulative procedure to assist with contracture release):
- 9921x—Established patient visit
- 29130—Application of finger splint, static (if a splint is created and applied at this visit)
- Supplies—As appropriate

Be sure that documentation captures the splint fabrication and the supplies. Make sure that reporting of services is both accurate and according to payer rules (eg, Medicare direct vs. incident-to-billing) if the splint fabrication is performed by a practice-employed therapist.

Because some payers may recommend using the unlisted code (26989—unlisted procedure, hands or fingers) on the second day for the cord manipulation and disruption of the cord, instead of reporting the E&M code, knowing the payer rules is important. NHIC Corp., a Medicare contractor in the New England states, requires use of the unlisted code to report the finger extension manipulation on the second day.

Modifier 51 or modifier 59?

Q. Should we use a modifier 51 or modifier 59 when the surgeon performs and documents a repair of the flexor profundus and the flexor sublimis, in zone 2 of the left index finger? The repair was necessitated by an acute laceration to both tendons.

A. This case has the following three key considerations:
1. Both repairs are to flexor tendons.
2. The tendons are in the same finger, same zone.
3. The repair of both tendons is defined by the same CPT code, 26356—Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man’s land); primary, without free graft, each tendon.

The correct way to report this is to use modifier 59 on the second procedure code to indicate that surgery was performed at a separate location. Under CPT rules, modifier 59 is used when it is necessary to identify two procedures as distinct from each other. In this case, the rules apply because the surgeon has performed the same exact surgery on two different tendons (separate site, even though it is the same zone, same finger). Using modifier 51 would not differentiate the two procedures from each other. If the payer requires the “F” modifier, it can be appended as the only modifier for the first code and as the second modifier for the second code (Fig. 1).

Q. If the surgeon repairs a flexor tendon in the wrist and an extensor tendon in the same wrist, should modifier 51 or modifier 59 be used?

A. In this case, the key considerations are as follows:
1. The tendons are not the same; one is a flexor tendon and the other is an extensor tendon.
2. The tendons are in the same wrist, but this has no effect on CPT code selection.
3. The procedures are defined by different CPT codes. The flexor tendon repair code is 25270 to indicate multiple procedures performed during the same surgical setting (Fig. 2). Under CPT rules, using modifier 59 in this code combination would be incorrect because the two procedures do not qualify as “distinct procedures.” The two procedures are separate surgeries, unrelated to each other and not inclusive to each other by the nature of their definitions.

One of the reasons modifiers 59 and 51 are frequently confused has to do with the original intent of modifier 59. Modifier 59 was originally meant to allow surgeons to receive 100 percent of the payment when multiple procedures were performed during the same session, provided certain criteria were met (such as separate sites, separate incisions, or different locations).

Over time, the use of this modifier changed and it became known as the “unbundling modifier.” Many coders make the mistake of using modifier 59 only to override payer edits. Coding for hand surgery procedures requires an understanding of the coding rules for using modifier 59.

Arthroscopy

Q. The surgeon performed an arthroscopy for irrigation and débridement of an infected interphalangeal joint, placement of a drain, and a 5 cm layered repair during the global period of a joint laceration repair. What CPT code should be used for the drain?

A. There is no CPT code for the placement of a drain. In this scenario, the major procedure is the arthroscopy, which includes both the repair and the drain placement.

The correct CPT code is 26080—Arthroscopy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each. Because a postoperative infection developed during a global period, modifier 78 should be appended to the arthroscopy code (Fig. 3).

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