Example 1: Options for coding closed treatment of ulnar shaft fracture without manipulation

Patient with an isolated, nondisplaced ulnar shaft ("night stick") fracture (25530) is seen in the office. Ignoring the effect of the geographic practice cost index (GPCI) and the budget neutrality (BN) adjustor, the total relative value unit (RVU) (work, practice expense, and malpractice) is 6.11. A payor using the CMS conversion factor (CF) (current through June 30, 2008), would reimburse as follows:

Global Billing

6.11 × \$38.0870 = \$232.71

This includes applying the initial splint or cast and follow-up for 90 days (but excludes billing for replacement casts/splints, supplies, and X-rays as appropriate). Based on a limited encounter, the concurrent E/M office service that resulted in the decision for the closed treatment of the fracture is not reported.

Itemized Billing

Code the appropriate E&M code based on category and level of service. This example assumes an initial new patient, level 3 E&M service, and subsequent level 2 E&M established patient visits. Levels of service will differ depending on the E&M services required by the patient and will affect the monetary calculations.

Initial encounter—
- 99203 (new patient): 2.55 RVU

Application of an initial
- short arm cast (29075): 2.14 RVU

Second encounter—
- 99212 (established patient): 1.03 RVU

Third encounter—
- 99212 (established patient): 1.03 RVU

Calculations:

2.55 × \$38.0870 = \$ 97.12
2.14 × \$38.0870 = \$ 81.51
1.03 × \$38.0870 = \$ 39.23
1.03 × \$38.0870 = \$ 39.23
Total = \$257.09

Note: These calculations do not include the GPCI or BN adjustors; they do use the Medicare Conversion Factor (CF) as of June 2008. Without Congressional action, the conversion factor converts to \$34.0862 on July 1, 2008.

Treatment reimbursement comparison

Global Reporting = \$232.71
(or \$208.27 with the lower CF)
Itemized Reporting=\$257.09
(or \$230.08 with the lower CF)

NOTE: Casting supplies and X-rays are not included because these are separately reportable in both scenarios, assuming the physician incurs the expense for the supplies and reports the radiology services.