Example 2: Options for coding closed treatment of a metacarpal fracture without manipulation

Patient with an isolated metacarpal fracture is seen in the office and managed by closed nonmanipulative treatment. 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) for the global fracture code (25500) is 6.50. A payor using the CMS conversion factor (CF) (current through June 30, 2008), would reimburse as follows:

Global Billing

6.50 × $38.0870 = $247.57

Based on a limited encounter, the concurrent E&M office service that resulted in the decision for closed treatment of the fracture is not reported.

Itemized Billing

Report appropriate E&M code based on category and level of service. Assuming that CPT code 99203 is the correct category and level of service, reporting would be as follows:

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 = $247.57
(or $221.56 with the lower CF)

Itemized Reporting= $257.09
(or $230.08 with the lower CF)

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