

Coding Corner

Hand and Upper Extremity

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Introduction

In pediatric hand and upper extremity surgery, numerous situations arise where there is variability or doubt in which code to use for a particular procedure. Was that an open reduction or closed reduction with percutaneous fixation of a fracture? Should we code trigger fingers and thumbs the same way? And when is post-axial polydactyly a reconstruction versus excision? This *JPOSNA*[®] Coding Corner will present case scenarios encountered by pediatric orthopaedic surgeons who care for common upper limb conditions. The intent is to provide guidance to aid proper surgical billing; however, it is important the ultimate code selection reflects the procedure performed and supporting documentation.

It's Friday and your day to run the upper extremity trauma room. Buckle up.

Case 1. Monteggia Fracture Dislocation

A 5-year-old girl is presented at trauma rounds with a Monteggia fracture dislocation. The evening prior, the resident attempted a closed reduction of the ulna shaft fracture; however, the radial head remains anteriorly

subluxated. The patient is taken to the OR where you find that the ulna can be reduced but it is unstable and maintenance of reduction is not possible by closed means. A small incision is made over the tip of the olecranon and an intramedullary Steinman pin is percutaneously introduced and placed intramedullary within the ulna crossing the fracture, stopping proximal to the physis. The fracture is reduced and stabilized, and the radial head is now congruently reduced on all views and with dynamic screening. There is no CPT code for percutaneous reduction. What code do we use and why?

Under CPT definitions, open treatment includes the use of an intramedullary implant even if there is no direct visualization of the fracture site. This is explained in the CPT guidelines which define open treatment as:

The site is opened surgically to expose the fracture/dislocation to the external environment for treatment or the fracture/dislocation is treated through the traumatic wound or an extension

hereof or is treated with an intramedullary nail or other internal fixation device placed through a surgical exposure that is remote from the fracture site with or without direct visualization of the fracture site.

As background, there are three CPT codes that specifically describe the use of an intramedullary implant for the femur, tibia, and humerus. For other long bone locations such as the radius, ulna, and fibula, where no specific intramedullary fixation code exists, this CPT guideline enables physicians to use an open treatment code instead of an unlisted code for intramedullary fixation, even when the fracture site is not directly visualized. The text was revised in 2022 to reinforce this point.

It can be confusing when physicians use the term “percutaneous intramedullary nail,” because a different set of codes are used to describe percutaneous skeletal fixation for fractures, where fixation is generally placed across the fracture (e.g., obliquely and through both cortices), but it is not contained completely within the medullary canal. We would recommend instead that the surgeon describe the treatment as intramedullary fixation in their documentation and not use the word “percutaneous,” as this may lead to confusion.

Returning to this specific case example, if the note describes intramedullary nailing of a Monteggia fracture dislocation, **code 24635** (*Open treatment of Monteggia type of fracture dislocation at elbow [fracture proximal end of ulna with dislocation of radial head], includes internal fixation when performed*) would be the appropriate selection.

Your next patient is ready.

Case 2. Radial Neck Fracture

A 7-year-old boy who fell running was seen in your department’s fracture clinic and indicated for surgery as the fracture was translated 50% and angulated 50 degrees. Your heart sinks. It’s a radial neck fracture. You have a surgical plan; however, you still feel lost

when it comes to appropriate billing. You hope it will go closed, however, maybe it will be unstable and need a percutaneous pin to hold the reduction? What about if I need to use a k-wire to manipulate the radial head into position and then place a percutaneous retrograde intramedullary wire from the distal radius metaphysis to hold the reduction?

A closed manipulated reduction of the angulated radial neck/head is usually performed with manual pressure (e.g., thumb) with or without the use of a tool that may be inserted “percutaneously” to assist in the manipulation/fracture reduction. This could be coded as a closed reduction, using **code 24655** (*Closed treatment of radial head or neck fracture; with manipulation*) with increased services modifier 22 for the percutaneous assistance. If percutaneous fixation is maintained, **unlisted code 24999** (*Unlisted procedure, humerus or elbow*) would apply, as there is no CPT code that describes percutaneous treatment of a radial neck fracture. If the fracture treatment involves the use of an intramedullary implant, again we would look at the appropriate open fracture code for the radial neck fracture. In this case, **code 24665** (*Open treatment of radial head or neck fracture, includes internal fixation or radial head excision, when performed*) describes the anatomic location and the method of treatment. Note that intramedullary nails/rods/pins should be contained within the intramedullary canal and cross the fracture site primarily in an orthogonal direction. They should not rely on external cortical contact/apposition to augment the fixation, as this would not be consistent with the mechanics of an IM implant (whether locked or unlocked).

But wait, there’s one more.

Case 3. Completely Displaced Distal Radius Metaphyseal Fracture

An 11-year-old girl fell off the trampoline onto an outstretched hand. She has a completely displaced distal radius fracture and is perimenarchal so leaving it to

remodel is not an option. This one is going to be easy, right!? However, the injury happened 3 days ago and she was referred to you for management by an outside orthopaedist. You take her to the OR and undertake the typical hyperextension/recreation of the deformity reduction maneuver. You just can't get it out to length, so you do a *mini-open* reduction levering the fracture from posteriorly using a freer elevator, successfully reduce the fracture, and then place a bi-cortical percutaneous pin to maintain the reduction.

In this scenario, the term *mini-open* reduction is used. By the CPT definition cited previously, the use of open treatment codes for non-intramedullary scenarios requires direct visualization of the fracture site; this is indicated by the statement that the fracture site is exposed to the external environment for treatment, whether through a surgical incision or a traumatic wound. If that exposure is not performed and documented, then **code 25606** (*Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation*) would likely apply.

Your trauma day ends.

The office awaits and you still have coding to complete from the OR and clinic earlier in the week. You are thinking how many different versions of triggers you have treated and that every other child must have post-axial polydactyly . . .

Triggers

Amongst the five trigger thumbs on Wednesday, there was a trigger finger. You released the A1 pulley and excised a slip of the FDS. Trigger finger release is typically reported using **26055** (*Tendon sheath incision (e.g., for trigger finger)*). That's what I used for trigger thumbs, should I use that for the trigger finger too? Should I add an additional code for the FDS slip excision?

This scenario does not indicate where the FDS slip excision is being performed. In June 2013, *CPT Assistant* advised that an ulnar FDS hemi-slip resection near the A1 pulley for treatment of trigger

finger is reported using **code 26170** (*Excision of tendon, palm, flexor or extensor, single, each tendon*).

Although not addressed in *CPT Assistant*, if the ulnar slip excision is instead performed at the A2 pulley in the finger, it would follow that **code 26180** (*Excision of tendon, finger, flexor or extensor, each tendon*) would apply. The key is that the physician's documentation must describe the location of the excision (palm vs. finger).

Keep in mind, under AAOS global service guidelines **codes 26170** and **26180** include incision or resection of the flexor tendon sheath and tenosynovectomy and/or tenolysis of flexor tendon, so CPT codes that describe those procedures would not be separately reportable for the same tendon.

Postaxial Polydactyly

Nearly there . . . In the office on Thursday, you saw a baby that you had clipped a floppy (Type B) postaxial polydactyly 2 weeks prior. At the time, you had performed a clinic visit, indicated the procedure, consented, and performed and billed the appropriate CPT code for the procedure. Does the procedure code include a 10-day global or 90 days?

Per CPT guidelines, excision of a soft tissue polydactylous digit is reported using **code 11200** (*Removal of skin tags, multiple fibrocuteaneous tags, any area; up to and including 15 lesions*). This instruction can be found following the definition of **code 26587** in the CPT book which states: "(For excision of polydactylous digit, soft tissue only, use 11200)." Under CMS definitions, **code 11200** is assigned 10 global days. **Code 26587** (*Reconstruction of a polydactylous digit, soft tissue and bone*) would be performed in an operative setting and is defined to include excision or reconstruction of bone as well as soft tissue. The CPT vignette for 26587 states "portions of the duplicate phalanges and metacarpals are removed and osteotomized as needed."

Summary

No case can be coded from a brief description, and these scenarios are starting points that must be confirmed through the operative note documentation.

When considering the management of fractures in the upper extremity, there are a few scenarios where specific intramedullary or percutaneous codes exist. Where they do not, in general, surgeons should only use open fracture codes when the fracture site is exposed to the external environment for treatment, whether through a surgical incision or a traumatic wound. When an instrument or wire is introduced percutaneously to aid closed reduction, then the closed codes are appropriate. Modifier 22 can be applied to signify increased procedural services when the work and documentation are appropriate. When percutaneous fixation is used and there is no percutaneous code option for the anatomic location, a corresponding unlisted code is appropriate using a different code as a comparison for the payor. Where intramedullary fixation is used, even when the fracture is not exposed, open reduction codes

may be used if the nail/device is contained within the intramedullary canal.

When it comes to the coding of common simple procedures such as trigger fingers and thumbs, it is important to note that some codes include the incision/resection of the pulley and tenosynovectomy, if performed. It is also important to note as precisely as possible where the tendon slip was excised as the coding is by region, palm vs. digit. Additionally, you cannot **code 26587** for a reconstruction when a simple excision is performed, such as with postaxial polydactyly. When using simple procedure codes, such as 11200, the global period may be only 10 days, and after you may resume clinic E&M billing.

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