

Internal Medicine Coding Alert

Modifier Review: Extremity Fractures: Learn Correct Modifier Usage

Tip: Repeating a procedure or service doesn't always mean extra pay.

With football season in full swing, outpatients and internists could be seeing more patients -- young and old -- with upper or lower limb fractures. You'll often need modifiers to accurately report X-ray services, so check two important areas to keep a clear view of fractures coding.

Confirm 50 or RT/LT for Bilateral X-rays

Internists often request X-rays for both limbs so they can compare the patient's anatomy or rule out multiple injuries (such as when the patient was involved in a traffic accident). In these cases, you'll report the appropriate X-ray code with modifiers appended to indicate the physician completed bilateral X-rays of the same body part.

Example: Mr. Thompson brings his 15-year-old son to your office with an apparent forearm fracture. The physician orders bilateral 2-view X-rays of the boy's forearms to confirm the diagnosis. You'll report 73090 (Radiologic examination; forearm, 2 views) for the procedure. Bilateral reporting will depend on the payer. Medicare often requires a single line item with modifier 50 (Bilateral procedure) appended to the procedure code. Other payers, however, might prefer two line items of 73090 with modifiers RT (Right side) and LT (Left side) appended to document bilateral status.

"It is more appropriate to use RT (Right side) and LT (Left side) when reporting X-rays," says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, Cal. "The specific modifiers help payers differentiate between multiple views of the same area versus bilateral views for comparison."

Tip: Verify that the internist can justify the X-ray on the asymptomatic or non-painful side. Physicians often order bilateral X-rays for children so they can compare the growth plates in the two limbs to help diagnose a fracture. The extra X-ray might not be necessary in adults, depending on the circumstances.

"Taking X-rays for comparison is up to the provider as part of the evaluation and management of the patient's condition," says **Denise Paige, CPC, COSC**, with Bright Health Physicians in Whittier, Cal.

If the internist orders X-rays of an unaffected area for comparison reasons, link the X-ray code with diagnosis V72.5 (Radiological examination not elsewhere classified). "Using this diagnosis code may result in a denial from the carrier, but it's correct coding," Paige says.

Payment: Reimbursement for claims using modifier 50 can vary, depending on the payer. CMS allows 150 percent reimbursement for procedures that allow modifier 50, but some payers allow full reimbursement for each side.

Remember 76 for Repeated Procedure

If the physician completes the same procedure for the patient twice in one day, remember to append modifier 76 (Repeat procedure or service by same physician or other qualified health care professional: it may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service) to the procedure code.

"Modifier 76 is often added for post-reduction films after a fracture reduction in the office or ER," says **Bill Mallon, MD**, medical director of Triangle Orthopedic Associates in Durham, N.C.

Example: If you read that after diagnosing a fracture on an X-ray, the reduction of the fracture was again confirmed on X-

ray, you append modifier -76. A sample procedure note might read, "Under muscle-relaxing anesthesia, a closed reduction was performed and the elbow was extended, distracted, and then gently flexed to lock the fragment in place. The reduction was then confirmed on X-ray." In this situation, you would report code 73080 (Radiologic examination, elbow; complete, minimum of 3 views) in addition to 24577 (Closed treatment of humeral condylar fracture, medial or lateral; with manipulation). Append modifier 76 to 73080 to specify that the physician repeated the X-ray.

Payment: CMS classifies modifier 76 as "informational." Appending modifier 76 to a procedure code gives the payer more details about the encounter, but does not affect the physician's reimbursement. Your provider should be paid the full amount for each set of X-rays.