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Part B Insider (Multispecialty) Coding Alert

E/M Coding: Know These E/M Rules to Avoid Fracture Care Fails

Hint: Review E/M modifier usage and append if necessary.

When you provide fracture care for a patient, you will very likely perform a separate E/M prior to the fracture care. How this separate E/M is reported depends entirely on the payer, however. Check out what the pros have to say about how to separately code an E/M service and fracture care on your claims.

Observe Payer Specificities on Fracture Care E/Ms

For most E/M services that result in fracture care with a 90-day global period, you should use modifier 57 (Decision for surgery) on the E/M code, says **Dawn Rogers,** orthopedic coding specialist at Caduceus Inc. in Jersey City, New Jersey.

You should append modifier 57 only when the procedure is major, which means it has a 90-day global surgery period. If you perform the E/M service along with a minor procedure (zero or 10-day global period) on the same date, you'll instead use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service).

Benefit: Most insurers accept modifier 57 for these encounters because it tells them that a full review was necessary to assess the decision for surgery. Without the 57 modifier, the patient's visit would be normal preoperative care, and payers would bundle it into the procedure code, Rogers explains.

Example: In California, non-health maintenance organization (HMO) Medi-Cal now requires a 57 modifier for any 90-day global service, which is new since they implemented use of the [Correct Coding Initiative] CCI edits about three years ago. So, when it comes to which modifier to use on pre-E/M fracture care claims "it really is hit and miss and can change," explains **Sharon Richardson, RN,** compliance officer for E /M services at Emergency Groups' Office in San Dimas, California.

Payers Muddy Modifier Waters With 25 Decision

While you'll be using modifier 57 on most pre-fracture care E/Ms, there's not a cut-and-dried answer to the modifier question when you're talking about fracture care coding and separate E/Ms. The modifier you use now depends on the payer, says Richardson.

"Medicare used to always require a 57 modifier when the decision to 'do surgery' was made at the time the patient was initially seen and the procedure had a 90-day global period attached to it," she explains.

But this is not necessarily true anymore. Some Medicare administrative contractors (MACs) still require modifier 57 in these situations, but others want modifier 25, Richardson says.

For example, **Catherine Brink BS, CMM, CPC, CMSCS, CPOM**, president of Healthcare Resource Management Inc. in Spring Lake, New Jersey. says the 25 or 57 decision would depend on the number of days in the surgical package for her payers - modifier 25 for E/Ms prior to a fracture care treatment with a 10-day global, and modifier 57 for an E/M before surgery with a 90-day global.

Do this: Check all of your contracts before filing another preoperative E/M service along with a fracture care code.