Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Ethically Add Dollars to Your Fracture Care Claims

Use these tips to decide whether E/M or fracture care is the way to go

Wondering when you should report fracture care instead of an E/M service? You are not alone.

Coders will not find a clear-cut answer to when they should report fracture care and when they should bill an E/M service and casting instead.
Experts say that the proper code selection will likely depend on the individual case. Take the following factors into account when making your decision to find the best fit for your claim.

Consider Fracture Care for Global Care

When you are wondering whether you should report fracture care, consider whether the scenario meets the following criteria:

- The physician is seeing the patient for her initial visit for the injury (fracture or dislocation).

- The injury is recent enough that it has not already healed on its own.

- The patient has not had surgery for this injury by another physician in a different practice. (For example, if the patient was injured while on vacation, had surgery and now is home and seeking follow-up, you cannot bill fracture care.)

- The physician provides a restorative treatment or procedure and plans to care for this injury for the next 90 days.

Example: A patient presents with pain and swelling in his ankle following a basketball injury that occurred the previous day. Your physician diagnoses the patient with a closed bimalleolar ankle fracture and performs closed treatment without manipulation.

Solution: You report 27808 (Closed treatment of bimalleolar ankle fracture [including Potts]; without manipulation) linked to 824.4 (Fracture of ankle; bimalleolar, closed).

Opt for E/M and Casting in These Instances

There are also several common instances when you should not bill fracture care codes, including the following:

- The fracture is old.
- There is a nonunion of the fracture.
- The fracture has healed or mostly healed.
- The physician is not providing a restorative treatment or procedure for which he is going to assume follow-up care for the next 90 days.
- The physician doesn't recommend follow-up visits.
- The physician refers the patient for a more extensive procedure, such as open treatment with or without fixation.

In the above cases, you should bill the appropriate E/M service, such as 99201-99215 (Office or other outpatient visit ...), with the appropriate casting and strapping application codes (29000-29590), where applicable, instead of a global fracture care code.

Remember: When you code application of casts and strapping (29000-29590) and an E/M service, you should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

Suppose your physician casts an established patient's finger after performing a level-two E/M. On the claim, report the following:

- 29086 (Application, cast; finger [e.g., contracture]) for the casting.

- Either 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) or Q4050 (Cast supplies, for unlisted types and materials of casts) for the casting supplies, depending on the payer.

- 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making) for the E/M.

- modifier 25 linked to 99212 to show that the E/M and casting were separate services.

Generate More Revenue With Same Work

If you are in the habit of billing an E/M code and the applicable casting code instead of fracture care, you could be losing money to the tune of $100 or more per claim. Conse-quently, you should start rethinking your protocol for finger splint and toe strap coding.

Consider the work involved in splinting a finger by comparing 26750 (Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each) to 29130 (Application of finger splint; static) for a closed fracture of the distal phalanx (816.02, Fracture of one or more phalanges of hand; closed; distal phalanx or phalanges). Often, physicians will bill for placing a finger splint with an E/M service code and 29130.

But these cases usually meet the definition of fracture care, says **Jeffrey F. Linzer Sr., MD**, associate medical director for compliance and business affairs at **EPG** in Egleston, Ga. You place the same splint in either coding scenario. The physician doesn't refer the patient to an orthopedist and sees the patient for follow-up.

The difference: Billing 26750 rather than 29130 is a difference of $127.33. Medicare's national physician fee schedule pays unadjusted rates of $165.99 (4.38 transitional nonfacility total relative value units) for fracture care versus $38.66 (1.02 RVUs) for the splint.

The breakdown: Code 26750 has a 90-day global period compared to a zero-day global period for 29130. -Anytime the patient returns within 90 days to see how the fracture is doing, the follow-up care is included in the procedure price of the fracture care,- Linzer says. Because the E/M service and finger splint option has zero global days, you would, however, bill an E/M service for follow-up visits.

Now look at how reporting fracture care rather than toe strapping can boost a claim. For example, A patient comes in after stubbing her big toe. The physician looks at the x-ray, diagnoses a closed fracture (826.0, Fracture of one or more phalanges of foot; closed), straps the toe to the adjacent one and tells the patient to wear sturdy shoes for a while for added protection. The physician codes no separate E/M service.

Your options include reporting:

- 28490--Closed treatment of fracture great toe, phalanx or phalanges; without manipulation
- 29550--Strapping; toes.

The physician performs the same work in both coding scenarios, Linzer says. She makes no referral to the orthopedist

and may see the patient for follow-up.

But reporting fracture care with 28490 pays $87.54 more than using the toe strap code. Code 28490 has 3.30 RVUs ($125.06) and 90 global days compared to 0.99 RVUs ($37.52) and zero global days for 29550.

Code In-Global Service Based on Reason

Just because fracture care codes include related follow-up care doesn't mean you will not report a code for any follow-up visits. Look at why the patient presents for the visit and code based on these guidelines:

1. If the E/M service during the global period is related to the original procedure, report the included follow-up care with 99024 (Post-operative follow-up visit, normally included in the surgical package ...) and a $0 charge.

2. When your physician sees a patient during the fracture care global period for an unrelated problem, such as swimmers- ear (380.12, Acute swimmers- ear), add modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the E/M service.

-The E/M has to be for a whole different issue,- Linzer says.

Tip: In a group practice, flag the chart to make sure a fellow physician includes follow-up care when the treating physician reported global fracture care, says **Richard H. Tuck, MD**, of **Prime-Care of Southeastern Ohio**. That way, the second physician won't accidentally use an office visit code to report follow-up care.