# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: For Multiple Fracture Repairs,Take Into Account E/M and Modifier 51

**Don't miss this 2016 Medicare guidance for global fracture treatments.**

Miscoding when your surgeon in the ED provides multiple fracture repairs in the same session can mean you're missing out on deserved payment. Read on for advice on how to appropriately list fracture services, beginning with the highest value code.

**Tip 1: Capture All Services**

You should list all fracture repair services that your surgeon provides to keep from omitting work units for any fracture that your surgeon is treating.

**Example:** You may read that for a patient who presented to the ED with a swollen foot after a road traffic accident, your clinician obtained a history, did a detailed clinical examination and diagnosed fractures in the left talus and calcaneus. Both the fractures were closed fractures and your surgeon did manipulation to treat the calcaneus fracture. In this case, you will report the E/M and the closed treatment of both fractures. In addition, you also append appropriate modifiers.

For the closed treatment of a calcaneal fracture, including the manipulation that your surgeon does, you report 28405 (Closed treatment of calcaneal fracture; with manipulation)  LT (Left side). For the repair of the talus fracture, you report code 28430 (Closed treatment of talus fracture; without manipulation) - LT. However, you cannot report both.

**Best bet**: Medicare allows only one global fracture treatment code to be reported in this scenario.  From Medicare's National Correct Coding Initiative 2016: "If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment without manipulation CPT® code may be reported."

**Tip 2: Bill the Appropriate E/M**

For E/M, you turn to 99283 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity ...). You bill the appropriate level of E/M based upon whether the patient was admitted or simply seen in the ER. In general, you will not bill this as a consult, even if the health plan still allowed for a consult as requests to see patients with a known fracture from the ED is a transfer or care and not a request for an opinion.

You append modifier 57 (Decision for surgery) to 99283 to show that the surgeon decided on surgical treatment based on the E/M provided. Your physician would need to add modifier 57 to the E/M visit to report the decision for surgery.

**Tip 3: Pick Up the Right Code for Modifier 51**

You append modifier 51 (Multiple procedures) to code 28430 to show that the two repairs were separate procedures. Where you append the modifier 51 is going to make a difference in your payment.

In the example above, you append modifier 51 to 28430 to earn your deserved payment as the payer will pay a modifier 51-appended code at 50 percent its total value. This will need you to revisit the RVUs before you can append the modifier 51 in your claim. Most insurance carriers will determine the highest paying RVU procedure for 100 percent of the allowable fee schedule, and deduct secondary procedure payments accordingly.

However, you may like to check with your payer. Some insurance carriers prefer that you do not use modifier 51 as they determine the primary procedure, experts say. Using the modifier 51 pre-determines the primary and secondary procedures but this may not be the highest paying procedure in all cases, i.e. you may have pre-contracted with a carrier with certain procedures values.

Pay attention to the sequence in which you report the codes for the multiple fracture repair services. "The bottom line here is you must always sequence your highest valued CPT® code first on the claim form or you will cost yourself reimbursement dollars," 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, CA. "If your reimbursement rate is based on RVUs, sequence the highest RVU valued code first. If your reimbursement is not based on RVUs, sequence the highest paying code first."

**Tip 4: Reporting Multiple Fractures? Add Up Your RVUs**

Not paying attention to work units for all the fractures that your surgeon is treating can turn these procedures into a cash sink hole. The solution? Ensure you are paid the highest value code at the highest percent of payment and keep in mind that codes submitted beyond the first may then be reimbursed at half of their values. Follow our expert advice on sequencing.

**Grasp Hierarchy Fundamentals**

You'll order your fracture codes using the RVU listing for the fracture codes. The services should be listed in order of RVU hierarchy on the claim form to avoid potential issues under reimbursement. Improper ordering can lead to a multiple procedure discount on a higher valued procedure if the highest valued procedure is listed in the secondary position, experts say.

Since payer policies vary, check with your payer to verify sequencing. In general, you should try to report these based upon the RVU value for the fracture management; however, Medicare and many other but not all health plans state that they pay based upon RVU, not based upon order in which the codes appear on the claim.

**Example 1:** If your surgeon is treating closed fractures in the left talus and calcaneus and does manipulation to treat the calcaneus fracture, you report codes 28405 (Closed treatment of calcaneal fracture; with manipulation)-LT and 28430 (Closed treatment of talus fracture; without manipulation)-LT.

You list the RVUs for the codes for the calcaneus (28405) and talus (28430) fractures. Code 28405 is worth about $404.23 (11.29 transitioned facility RVUs multiplied by the 2016 Medicare conversion rate of 35.8043). The 28430 code is worth about $243.11 (6.79 RVUs multiplied by 35.8043).

Since the payer will pay a modifier 51-appended code (28430) at 50 percent its total value, you see that your payment for 28430 will reduce by half, i.e. $121.56. On the other hand, if you report the reverse order in the example above, i.e. you append modifier 51 to 23405, you are certain to lose much more on your payment. Your payment will now fall by half of the 28405 value, i.e. by about $202.12.

So, the correct order of the claim will be 28405, 28430-51. This helps you to maximize payment.

**Example 2:** Suppose you report code 27506 (Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws) with RVU 38.56 and 25609 (Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments) with RVU 30.05. If listed in the correct order, your reimbursement would equal RVU 53.59.

If the treatment of the radius fracture was listed first on the claim and the multiple procedure discount was taken on the femoral fracture treatment service, your RVU's would equal 49.33. Your loss in reimbursement would be 4.26 RVUs for the improperly ordered claim.

**Severity of Injury Is Not a Good Guide**

Another approach you may be adopting could be to list the procedures in order of the severity of injury. A good example is say a multiple trauma patient who has fracture of the left femoral shaft, closed trimalleolar fracture of the right ankle and right talus, distal radius, and an open supracondylar fracture of the right femur.

For instance, you may read that the fracture in the left femoral shaft was treated with IM nailing and you report code 27506 (RVU 38.56). You may also read that the ankle fracture was treated by ORIF including fixation of the posterior malleolus for which you report codes 27823 (Open treatment of trimalleolar ankle fracture, includes internal fixation, when performed, medial and/or lateral malleolus; with fixation of posterior lip) (RVU 27.47) and 28445 (Open treatment of talus fracture, includes internal fixation, when performed) (RVU 30.60). For closed reduction of the fracture in distal radius, you report code 25605 (Closed treatment of distal radial fracture [e.g., Colles or Smith type] or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation) (RVU 15.56). There is no documentation of debridement for the open fracture in the right femur, you report code 27511 (Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed) (RVU 28.74) for the open reduction and internal fixation that your surgeon does.

Technically the open fracture is the more severe injury and should be listed first; however, the RVUs for the supracondylar fracture are actually less than for the IM nailing of the femoral shaft. In general, you should bill this scenario in the following order which would be RVU based:  27506, 28445, 27511, 27823, and 25605.

**The bottom line:** You should always bill in order of decreasing RVUs rather than severity.