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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Review Possible Additional Services With This Q-and-A

Know how to code secondary issues in fracture encounters.

There's no denying that fracture care is one of the more common services orthopedists provide. But issues with secondary injuries may arise, and this may require more nuanced coding.

When the fracture care is complete and it's time to code, however, you might be able to report more than a single fracture care code for your orthopedist's services. The trick is knowing when a service is separately codeable and how to report it. This often involves the proper use of modifiers, or the knowledge to leave certain modifiers off of claims.

We've compiled a primer on three scenarios in which you might code for more than just a single fracture care code. Check out what our experts had to say about properly adding codes to fracture care claims.

Q: When a patient reports with multiple fractures, how does the coder decide which fracture to report first?

A: "The fracture treatment code with the highest RVUs [relative value units] would be coded first with each fracture thereafter listed in the order of RVUs," explains **Sharon Richardson, RN,** compliance officer at Emergency Groups' Office in San Dimas, Calif.

You might, or might not, want to append modifier 51 (Multiple procedures) to the code with the lower RVUs; it's still listed in CPT®, but most insurers consider the modifier extinct.

When you need to use it, apply modifier 51 "to the secondary procedure to inform the insurance company of multiple procedures by the same provider during the same surgical setting," according to **Dawn Rogers,** coding specialist at Caduceus Inc. in Jersey City, N.J.

However, "most insurance companies no longer recognize the 51 modifier as it is redundant to their reimbursement structure. They will automatically reduce reimbursement of the second and following procedures according to the contract agreement," says Rogers.

Best bet: Consider the payer when considering modifier 51 on your multiple fracture claim. If the payer doesn't want modifier 51, it never hurts to list the higher-RVU code first on your claim so it's the first one the payer sees.

Example: The orthopedist performs repair of a closed tibial shaft fracture using manipulation and skeletal traction; he also performs closed repair of a nondisplaced fracture of the patient's distal radius without manipulation. You'd report 27752 (Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction) for the tibial fracture fix and 25600 (Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation) with modifier 51 appended for the distal radial fracture repair, if the payer requires it, to ensure the reduction is applied to the lower-paying code.

Q: Could a separately codeable wound care accompany a fracture repair?

A: "In my experience the answer is yes," says **Marcella Bucknam, CPC, CCS-P, COC, CCS, CPC-P, CPC-I, CCC, COBGC,** revenue cycle analyst with Klickitat Valley Health in Goldendale, Washington.

"These encounters would usually involve "a fracture, typically an open fracture, or some other open wound with damage

to an underlying musculoskeletal structure: bone, tendon, ligament, cartilage, etc.”

There are three distinct levels for wound care; check out this quick rundown of each level's code sets and repair characteristics:

Simple repair: Report codes from the 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less) through 12021 (Treatment of superficial wound dehiscence; with packing) code set.

Characteristics: Bucknam explains that "simple closure is closure of only the skin in a single layer using sutures, staples or even adhesive skin glue. It is typically only separately billable if it is the only procedure being performed. It would bundle into virtually any MS [musculoskeletal] procedure performed at the same site. These are simple wounds that only need to be reapproximated in order to heal.”

Intermediate repair: Report codes from the 12031 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less) through 12057 (Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm) code set.

Characteristics: Bucknam says "an intermediate closure is a layered closure. The provider should either document reapproximation of the subcutaneous tissues followed by separate closure of the skin or specify that the wound was closed in layers. Again, intermediate closure is often bundled into ortho procedures at the same site because MS structures are, by definition, below the subcutaneous tissue and you can't bill separately for closure of operative procedures.”

Complex repair: Report codes from the 13100 (Repair, complex, trunk; 1.1 cm to 2.5 cm) through +13153 (Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)) code set.

Characteristics: According to Bucknam, "complex repair starts with layered closure and then has more. The most common complex closure is a layered closure where there is undermining or loosening of the skin from the subcutaneous tissue in order to pull the skin to close a larger defect. However, complex closure can also be billed when the surgeon creates the defect - for example, a scar revision. There must be documentation of the layered closure as well as good and believable documentation of the extra work required for the complex closure.

"It's also important to remember that all of these repairs are in essence skin repairs,” Bucknam continues. "If a repair involves other types of tissues (e.g., fascia repairs, graft repairs), there are other codes in the MS chapter to describe those services.”

Q: What modifier would you use for a wound care code that accompanies fracture care?

A: You would apply the same rules that you would apply for multiple fractures; append modifier 51 if the payer requires it, or the payer will make a determination based on the pay schedule for each code.