Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Scan Fracture Notes for Presurgical E/M Services

Tip: Global period determines modifier.

Orthopedic surgeons often perform a significant, separately identifiable E/M service before administering fracture care.

Plus, you can code for that separate E/M as long as you can prove it is truly separate - and remember to append the proper modifier to the E/M code.

Read on to find out how to spot potential E/M services in your fracture care encounter notes.

E/M Typically Precedes Fracture Care

When a patient presents with a fracture, the physician almost always will perform a separate E/M service before treating the injury, explains **Sharon Richardson, RN,** coder in San Dimas, California. "We would need to do at least a problem focused history to find out if the patient has any medical conditions that would prevent them from being treated, anything that would slow down healing, any allergies to the medication that might be used to treat the fracture, etc."

Also, if a patient suffers a fractured bone, "there is the high probability that there are other injuries also requiring at least a problem focused exam." So, odds are pretty high that a patient walking through your door for initial fracture care will need a separate E/M as well.

Potential exceptions: If a patient already has a fracture diagnosis and your surgeon is just performing the fix, then there might not be a chance for a separate E/M. For instance, if your surgeon treats a patient that was sent from the emergency department (ED), the ED will likely perform the E/M first. Also, patients arriving for surgery on referral from other providers with a fracture diagnosis on record might not need a separate E/M.

Make 25/57 Decision Based on Global

Once you've found a separate E/M in your fracture care claim, you'll need to decide on the proper E/M modifier: 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) or 57 (Decision for surgery).

The difference: "Like the 57 modifier, the 25 modifier separates an encounter from a procedure for reimbursement. The difference is the global period or, in other words, minor versus major procedures," says **Dawn Rogers,** coding specialist at Caduceus Inc. in Jersey City, New Jersey.

You should apply modifier 25 to E/Ms that accompany surgical codes with global periods of 10 days or less; opt for modifier 57 on E/Ms with surgeries that have 90-day global periods.

For fracture care coding, you won't run into any claims where you'll use modifier 25 on your E/M. This is because all fracture care codes have 90-day global periods.

Tip: If you're coding for any E/M that accompanies a procedure with a global of 10 days or less, always append modifier 25 to the E/M.

Example: Code 27503 (Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction) has a global period of 90 days, so you'd append modifier 57 to any separate E/M service that accompanies this surgery.

Review This Clinical Scenario

If you're having trouble envisioning what an E/M-fracture care scenario would look like, check out this example from Richardson:

A 67-year-old established male patient reports to the orthopedist a day after falling from a 5-foot ladder. He has severe pain in his right lower extremity and is unable to ambulate. Due to his age the physician performs a detailed history. The patient has a history of diet-controlled diabetes and mild chronic obstructive pulmonary disease (COPD); because of his history, the physician performs a detailed physical exam.

The patient's lungs are clear, heart sounds are normal, extremities well perfused without edema except to the affected extremity; vital signs normal and accucheck is 112. The physician consents the patient and then manipulates the fractured bones with X-ray, showing well-aligned tib-fib; the patient is then casted, counseled on treatment for the injury, prescribed medication, and sent home. Final diagnosis is mildly displaced tibial shaft fracture.

For this claim, you've got a separate E/M that precedes the fracture care. On the claim, you'd report:

- 27752 (Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction)
- 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity ...)
- Modifier 57 (Decision for surgery) appended to 99214 to show that it is a separate service from the fracture care
- S82.201A (Unspecified fracture of shaft of right tibia, initial encounter for closed fracture) appended to 27752 and 99214 to represent the patient's injury.