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Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Coding 'Comfort' Visits as Fracture Care Can Land You in Hot Water

Plus: Don't forget to bill supply codes to Medicare.

A patient reports to your practice with a broken bone. The physician treats her and sends her home. This is automatically a fracture care claim ... right? **Wrong:** Even if the physician confirms a fracture, this does not guarantee you can choose a fracture care code.

When examining a claim, the coder should ask herself: Did the physician treat the patient's fracture,or did he just make the patient more comfortable? If he just makes the patient comfortable, then you cannot code fracture care.

Example: The physician treats a patient with a suspected right leg fracture; she examines the leg, takes a pair of x-rays, and determines that he has a closed tibia fracture. She puts the leg in a splint, and then advises the patient to visit an orthopedist as soon as possible for additional treatment, including casting.

This is an E/M service, not fracture care. On the claim, you'd likely report an E/M code for the encounter. So if the physician provides mostly comfort measures and the patient is sent to a different specialist (such as an orthopedic surgeon) for more definitive care (such as casting), code only for the E/M. If the physician definitively treats the patient's fracture, however, you'd report a fracture care code.

Example: The physician treats a patient with a suspected right leg fracture; she examines the leg, takes a pair of x-rays, and determines that he has a closed tibia fracture. She resets the bone and places his lower leg in a plaster cast. She then advises the patient to schedule follow-up visits with an orthopedist.

For this encounter, you can report an E/M and a fracture care code. On the claim, report the following:

• 27752 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; with manipulation, with or without skeletal traction) for the fracture care

• The appropriate-level E/M code based on notes

• Modifier 54 (Surgical care only) appended to 27752 to show that you are not coding for the patient's follow-up care

• Modifier 57 (Decision for surgery) appended to the E/M to show that it was a separate service from the fracture care.

Note: Some non-Medicare insurers may want you to 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 instead of modifier 57.

"Some payers follow the rule that modifier 25 would be used if the global days [of the CPT code] were 0-10, and modifier 57 would be used when global days are 90 or greater," explains **Yvonne Bouvier, CPC,** senior coding analyst with Bill Dunbar and Associates in Indianapolis.

So a fracture care code such as 21310 (Closed treatment of nasal bone fracture without manipulation), which has a 10-day global, might prompt you to append modifier 25 to the E/M instead of 57

Report Casting Supplies

You can report supplies on the same date that you charge fracturecare, says **Shelly Kirk, CPC,** with Tennessee

Orthopaedic Clinics in Knoxville.

Although you can bill the supplies, "you cannot charge for casting/splinting on the same date as charging fracture care," Kirk says. The cost of the actual casting or splinting service is included in the fracture care charge.

Supply tip: When billing Medicare, remember to report only one unit of each Q code for the supplies, Kirk says. If you're billing a different insurer, the payer may request that you report "A" codes instead of the Q codes, she advises.

"You'll report any additional casting on future dates of service with a casting/splinting code in addition to the supply codes for that date of service," Kirk says. "These services will be billed with a modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) if the patient is within a 90-day global setting forsurgical services billed."