# Part B Insider (Multispecialty) Coding Alert

## Part B Mythbuster: Make Your Global Period X-Ray Claims Picture Perfect

**Find out when to apply modifier 76.**

**Myth:** X-rays that you shoot or interpret during the global period are not billable to Medicare because payers include these charges in the surgical package.

**Reality:** Practices that don't bill their x-ray charges are throwing away thousands of dollars in rightful reimbursement.

**Scenario:** An established patient reports to your office with pain, swelling, and tenderness of the left wrist and forearm. The physician diagnoses the patient with a buckle fracture of the wrist, which he stabilizes with a splint before sending the patient home. The patient returns four weeks later and the physician takes two follow-up x-rays of the patient's forearm.

**Bill Those Follow-Up X-Rays**

**The challenge:** You should report fracture care (25600, 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; without manipulation) and any x-rays performed for the initial visit. But can you report the follow-up x-rays?

**The solution:** Go ahead and report those films. If your practice performed and interpreted the x-rays, report 73090 (Radiologic examination; forearm, two views).

X-rays determine the patient's condition and the course of care, so they are not included in global packages. You can also report any follow-up x-rays separately. If you don't separately report the x-rays, you risk losing significant reimbursement.

Because Medicare payers will reimburse about $28 each time you report 73090, failing to report the x-rays could be an expensive mistake over the course of a year.

When a fracture care code is selected, this only includes the initial casting and all follow-up visits within the 90 day global period. All x-rays, subsequent castings and supplies are not included in the fracture care code. These services and supplies are not considered as edits or mutually exclusive codes by the Correct Coding Initiative (CCI).

Billing x-rays outside of the global period doesn't apply only to fracture care claims. In fact, diagnostic services are not considered part of the global package in general, and may be billed separately.

Per the American Academy of Orthopaedic Surgery's Global service data guidelines and CCI, the only x-rays that are included in a procedure are those that are intra-operative, such as checking the placement if a manipulation was performed before the cast was placed. X-rays that are taken pre- and post-reduction , i.e. before manipulation and after manipulation and casting have taken place, are reported using the correct CPT® code from the radiology section and appending a modifier 76 (Repeat procedure or service by same physician or other qualified healthcare professional) to the post-reduction x-ray.