Codify
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Modifier Coding Alert

Modifier Madness: Sort Out Modifier Mess On Multi-Provider Fracture Care

When you divide fracture claims, providers engage in a 70/30 split.

Let's face it: When there are multiple providers involved in fracture care, breaking up the coding is hard to do.

If your provider performs only a portion of the fracture care service, proper coding depends on proper modifier use. Which modifier you will use, however, will depend on the portion of the service your provider performs.

Don't leave your claims in misery. Avoid accusations of overcoding and the ire of suspicious payers with this expert advice on coding for portions of fracture care service.

Pin 54 To Fracture Care Codes With 90-Day Globals

If your physician is only providing intraoperative care for a patient's fracture, append modifier 54 (Surgical care only) to the fracture care code, advises **Yvonne Bouvier, CPC, CEDC**, senior coding analyst for Bill Dunbar and Associates, LLC, in Indianapolis, Ind.

Remember, your physician cannot provide any of the postoperative care if you are reporting modifier 54.

Example: A patient reports to the emergency department (ED) with a visibly displaced right elbow. After an evaluation that includes an x-ray, the physician diagnoses a displaced radial head subluxation. On her first attempt, the physician reduces the dislocation. Then, she discharges the patient and instructs him to follow up with an orthopedist. In this instance, you should report 24640 (Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation) for the ED physician's fracture care with modifier 54 appended to show the payer that you are not coding for the postoperative care of the patient.

Reimbursement: You'll receive 70 percent of the payout for 24640, which is about $100 □ roughly 70 percent of $143, which is the average Medicare payout for 24640 (3.98 nonfacility relative value units [RVUs] multiplied by the 2015 Medicare Physician Fee Schedule conversion rate of 35.9335).

Best bet: Check the global period for the fracture care code before appending modifier 54. If the fracture care code has a 90-day global period, you must append modifier 54, says **Sharon Richardson, RN**, compliance officer for E /M services at Emergency Groups' Office in San Dimas, Calif. If it's a code that doesn't have a 90-day global period, reconsider appending modifier 54 as it may only be necessary with some payers.

Include 55 When Providing Only Follow-Up Care

Whenever a provider codes for the intraoperative portion of a fracture code using modifier 54, someone has to manage the postoperative care. If your office is the one that takes up the reigns of care after the initial treatment of a fracture, remember to append modifier 55 (Postoperative management only) to the same fracture care code that the initial physician reports.

Example: A patient sustains a right bimalleolar left ankle fracture while snow skiing on vacation. The physician surgically stabilizes the ankle, and directs the patient to report to his local orthopedist for aftercare upon returning home. His local orthopedist performs postoperative surgical care for the patient within the 90-day global window.

For this case, the first physician should report 27814 (Open treatment of bimalleolar ankle fracture [e.g., lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli], includes internal fixation, when performed), and attach modifier 54.

On his claim, the orthopedist would report 27814 with modifier 55 appended to show that he is only coding for the postoperative care. This encounter will net the orthopedist's practice about $240, which is 30 percent of the average Medicare payout for 27814 (22.26 nonfacility RVUs multiplied by 35.9335).

Good idea: If your office handles the postoperative portion of a fracture care package, contact the practice that provided the surgical care before filing your claim. This way, you'll know if the practice reported only the intraoperative portion of the service. If the other practice did not use modifier 54, and you report the fracture care code with modifier 55, the payer will deny your claim because they already paid the other physician the full surgical fee.