Modifier Coding Alert

Reader Question: Remember Modifier 51 for Payers that Still Require It

Question: Our orthopedic surgeon recently performed the following fracture care repairs for a trauma patient: closed treatment of a clavicular fracture without manipulation (23500) and closed treatment of a humeral shaft fracture without manipulation (24500). Do I need modifier 51 for this claim and, if so, which code should I append it to?

Mississippi Subscriber

Answer: The answer depends on whether or not your payer requires modifier 51 (Multiple procedures) when the physician performs multiple surgeries during the same session.

In short: When reporting for Medicare, and payers that follow Medicare rules, modifier 51 is often unnecessary, as the payers typically have software that properly orders the code to the benefit of the payee. In other words, these payers will pay the highest-paying code first (24500, Closed treatment of humeral shaft fracture; without manipulation), then apply the multiple procedures reduction to the lower-paying code (23500, Closed treatment of clavicular fracture; without manipulation). Thus, you should report the higher service first and the lesser-paying service second.

If you need modifier 51, however, be sure to report 24500 first, and 23500 with modifier 51 appended.

Reason: The 24500 code pays about $368 (10.27 nonfacility relative value units [RVUs] multiplied by the 2016 Medicare conversion rate of 35.8279); while 23500 pays about $226 (6.29 nonfacility RVUs times 35.8279). You want to be sure that the payer applies the 50 percent payment to the lowest-paying code on your multiple procedures claim (23500).

Again, check with your payer to see if you need modifier 51. It is rare, but there are still some payers, such as BlueCrossBlueShield of Mississippi, that still require modifier 51 in multiple procedure situations.