

Coding Corner
Fracture Care and ER Patients
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A frequent question is how to report fracture services when the patient is first seen by the Emergency Room (ER) physician and transferred to the Orthopaedic Surgeon for definitive treatment/care. This article addresses a recent question from an orthopaedic practice regarding recent denials on fracture care when the patient is first seen by the ER physician and transferred to their practice. The answer is not straight forward and is dependent on a variety of factors. Let's take a look at the scenario the practice presented and discuss the options on how to code for the orthopaedic services.

Question:

We have recently started receiving denials on fracture care when the patient is seen by the ER physician then sent to our office. We are not aware that the ER physician is billing the fracture codes.

- 1) Should ER physicians report fracture codes?
- 2) Can ER physicians bill for fracture care with the 54 modifier?
- 3) If the ER physician can report services with a 54 modifier can the orthopaedic physician bill for visits and not fracture care with the 55 modifier?
- 4) The 54 modifier reimburses at 69% and the 55 modifier only reimburses at 21%. How will we know when the ER is billing the same fracture CPT code?

Answer:

This is an ever challenging question and one that is difficult to manage, so let's look at a few points and see if we can clarify.

Reduction by the ER physician:

- If the ER physician sees a patient in the ER and reduces a fracture, the ER physician reports the appropriate fracture/dislocation CPT code defined with the terms "with manipulation" and appends a modifier 54 (surgery only). The ER physician should expect to receive 79% of the value of the code (the equivalent of the pre-op 10% and the 69% for the manipulation).
- The patient presents to the orthopaedic practice and there has been no official transfer of care (e.g. the orthopaedic surgeon did not agree in writing to accept the care of the patient, does not have the CPT codes reported, or the dates of service including the transfer date). In this case the orthopaedic surgeon will itemize/report all services using the appropriate E&M services, splint or cast applications, supplies, x-rays. The E&M will be appended with a modifier 25 if a splint or cast application is performed on the same day as the E&M. The orthopaedic surgeon does not enter into a 90 day global period.
- If an official transfer of care occurred, the orthopaedic surgeon will report the same CPT code as the ER physician with a modifier 55 indicating post-op only services. The orthopaedic surgeon will have to coordinate the transfer of care, obtain the CPT codes reported by the ER physician and correlate the dates of

service and the date of transfer to report on the claim. Because this typically does not occur, the best reporting option is the itemization of services.

- If the payor denies because the ER physician “forgot” to append the modifier 54, the orthopaedic surgeon will have good documentation that the fracture or dislocation was treated by another physician and the patient presented to your office. You will note in your appeal that there was no transfer of care. In this case, the payor will most likely demand a refund from the ER physician or ask for documentation to support reporting the global code.

Remember, if the ER physician performed a closed reduction, it is appropriate for the ER physician to use the fracture/dislocation CPT codes, but they must append the surgery only modifier (modifier 54) as they will not be providing the post-operative care.

Non Manipulative Management of the Fracture by the ER Physician:

The global fracture codes are intended for the physician who will be managing the patient’s care for the entirety of the restorative/healing process.

CPT 2009 addresses the application of the initial cast without restorative management in the Application of Casts and Strappings Section of the CPT Manual

The first paragraph in the Cast Application Section of CPT states, “The listed procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care, or when the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to a patient. ***Restorative treatment or procedure(s) rendered by another physician following the application of the initial cast/splint/strap may be reported with a treatment of fracture and/or dislocation code.***” Thus when the ER physician does not reduce a fracture and instructs the patient to follow up in the orthopaedic physician’s office, the ER physician is providing the “initial service without a restorative procedure” and should report the appropriate E&M-25 and splint or cast application as appropriate. The temporary splint/cast application for stabilization of the fracture is not included in the global fracture code.

This is further clarified in the third paragraph of the introductory guidelines.

“If cast application or strapping is provided as an initial service (eg, casting of a sprained ankle or knee) ***in which no other procedure or treatment*** (eg, surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, ***use the casting, strapping and/or supply code (99070) in addition to an evaluation and management code as appropriate.***”

It is not appropriate for the ER physician to report the non-manipulative global fracture codes if the ER physician sees a patient in the ER, places a splint or cast and instructs the patient to follow up in the orthopaedic office.

Let's put this into real life!

Patient is seen in the ER on Friday evening and the ER physician places a splint for a non displaced distal radius fracture.

Monday morning the patient arrives in the orthopaedic office and the physician agrees the fracture does not require manipulation. The orthopaedic surgeon has two options in reporting, itemized billing or global fracture billing.

Option 1: Itemized Billing Method (no global period) report as appropriate:

E&M-25

Splint or cast application

Supplies

X-rays

If no x-rays are required or a new cast/splint is applied then the only service reported is the E&M.

Global Fracture Billing (this assumes patient is seen on Monday, following the Friday injury)

Global fracture code

Supplies as appropriate

X-rays as appropriate.

If the fracture/dislocation was reduced, the decision on how to report is simplified. The challenge and decision making is necessary when the fracture is not manipulated and is initially managed by the ER physician and instructed to see the orthopaedic physician for definitive management