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HIGHMARK CODING TIPS

FEBRUARY, 2019

Coding for Closed Treatment of Fractures

There are two key factors in determining the appropriate coding for closed treatment of fractures.

- Determine whether the physician provides "restorative treatment" of the fracture. *Restorative treatment is defined as the manual application of force (eg. manipulation) and one must achieve satisfactory alignment of the facture/dislocation for healing and restoration of limb function.*
- Determine whether the same physician will be providing all the follow-up care within the 90-day global period.

Common Coding Scenarios:

Physician is providing restorative care of the fracture and all follow-up management

- Report the service with the global fracture care code

Physician is providing restorative care but not providing the follow-up care:

- Reporting the appropriate global fracture treatment code with modifier -54 to indicate only the intra-service work was provided
- The physician providing the follow-up care should report the same CPT with the -55 modifier for the subsequent evaluation during the remainder of the global period

Physician provides treatment for a fracture that does not require restorative care or post-service follow-up visits by the same physician:

- Report the appropriate E/M code as well as the code for application of a cast/splint, if applied

Initial closed treatment of fracture is provided in the ED by emergency physicians or other qualified healthcare providers:

- If fracture care meets the definition of "restorative treatment" by the ED physician, report the appropriate global fracture treatment code with modifier -54 to indicate only the intra-service work was provided.
- If the emergency physician does not provide restorative care, the correct and only method of reporting this service would be to use an ED E&M code, as well as the code for application of a cast or splint, if applied.

For additional information on appropriate use of modifiers 54 and 55, please see Highmark Reimbursement Policy RP-005.

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Maternity Related Anesthesia

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.