CODING  from page 29

- E&M services using established patient visit codes if the services are provided in the office (99210), or other E&M code that is specific to the service setting.
- Application of replacement cast(s) or splint(s), assuming the physician or supervised employed or contracted staff applies the cast or splint. Add modifier 25 to the appropriate E&M code if it is a “significant and separate service” provided in addition to the procedural service (such as application of the cast/splint).
- Supplies, if applicable, depending on the place of service.

When is closed treatment of fractures reported?
Closed treatment of fractures is commonly reported in two scenarios. One is when the injury requiring nonmanipulative treatment is the only procedural service performed by the physician (Examples 1 and 2).

As these examples show, the reimbursement is about the same, but different methods are advantageous for different situations. Itemized reporting requires the physician to have supporting monetary calculations.

Example 1: Options for coding closed treatment of ulnar shaft fracture without manipulation

Patient with an isolated, nondisplaced ulnar shaft (“night stick”) fracture (25530) is seen in the office. Ignoring the effect of the geographic practice cost index (GPCI) and the budget neutrality (BN) adjustor, the total relative value unit (RVU) (work, practice expense, and malpractice) is 6.11. A payor using the CMS conversion factor (CF) (current through June 30, 2008), would reimburse as follows:

**Global Billing**
6.11 × $38.0870 = $232.71

This includes applying the initial splint or cast and follow-up for 90 days (but excludes billing for replacement casts/splints, supplies, and X-rays as appropriate). Based on a limited encounter, the concurrent E/M office service that resulted in the decision for the closed treatment of the fracture is not reported.

**Itemized Billing**

Code the appropriate E&M code based on category and level of service. This example assumes an initial new patient, level 3 E&M service, and subsequent level 2 E&M established patient visits. Levels of service will differ depending on the E&M services required by the patient and will affect the monetary calculations.

**Initial encounter**—
99203 (new patient): 2.55 RVU
Application of an initial short arm cast (29075): 2.14 RVU
Second encounter—
99212 (established patient): 1.03 RVU
Third encounter—
99212 (established patient): 1.03 RVU
Calculations:
2.55 × $38.0870 = $97.12
2.14 × $38.0870 = $81.51
1.03 × $38.0870 = $39.23
1.03 × $38.0870 = $39.23
Total = $257.09

**Global Reporting**

Note: These calculations do not include the GPCI or BN adjustors; they do use the Medicare Conversion Factor (CF) as of June 2008. Without Congressional action, the conversion factor converts to $34.0862 on July 1, 2008.

**Treatment reimbursement comparison**

Global Reporting = $232.71
(or $221.56 with the lower CF)
Itemized Reporting=$257.09
(or $230.08 with the lower CF)

NOTE: Casting supplies and X-rays are not included because these are separately reportable in both scenarios, assuming the physician incurs the expense for the supplies and reports the radiology services.

Example 2: Options for coding closed treatment of a metacarpal fracture without manipulation

Patient with an isolated metacarpal fracture is seen in the office and managed by closed nonmanipulative treatment. Ignoring the effect of the geographic practice cost index (GPCI) and the budget neutrality (BN) adjustor, the total relative value unit (RVU) (work, practice expense, and malpractice) for the global fracture code (25500) is 6.50. A payor using the CMS conversion factor (CF) (current through June 30, 2008), would reimburse as follows:

**Global Billing**
6.50 × $38.0870 = $247.57

Based on a limited encounter, the concurrent E/M office service that resulted in the decision for closed treatment of the fracture is not reported.

**Itemized Billing**

Report appropriate E&M code based on category and level of service. Assuming that CPT code 99203 is the correct category and level of service, reporting would be as follows:

**Initial encounter**—
99203 (new patient): 2.55 RVU
Application of an initial short arm cast (29075): 2.14 RVU
Second encounter—
99212 (established patient): 1.03 RVU
Third encounter—
99212 (established patient): 1.03 RVU
Calculations:
2.55 × $38.0870 = $97.12
2.14 × $38.0870 = $81.51
1.03 × $38.0870 = $39.23
1.03 × $38.0870 = $39.23
Total = $257.09

**Global Reporting**

Note: These calculations do not include the GPCI or BN adjustors; they do use the Medicare Conversion Factor (CF) as of June 2008. Without Congressional action, the conversion factor converts to $34.0862 on July 1, 2008.

**Treatment reimbursement comparison**

Global Reporting = $247.57
(or $224.75 with the lower CF)
Itemized Reporting=$257.09
(or $230.08 with the lower CF)

NOTE: Casting supplies and X-rays are not included because these are separately reportable in both scenarios, assuming the physician incurs the expense for the supplies and reports the radiology services.