Insurance & Billing

At Coastal Orthopedics, we participate in most major insurance plans. However, we suggest you verify your eligibility and coverage for services with your insurance company.

Accepted Insurances:

Aetna, Allways, Blue Cross Blue Shield, Cigna, Fallon, Harvard Pilgrim, Medicaid, Medicare, Motor Vehicle Accident, Tufts, Tricare, Worker's Compensation. Please call to verify that we take your plan.

Clarification - Fracture Care Billing

Our office makes every effort to follow the current coding practices for reporting medical services as dictated by the Federal government (CMS) and the American Medical Association (AMA). These regulations can be quite complicated and generate many questions. The purpose of this page is to clear up any confusion caused by these complicated rules regarding the billing of fracture care services.

A fracture or "broken bone" is most often diagnosed by x-ray and can vary in severity and treatment options. However, for billing and insurance coding purposes, **fracture care is listed in the surgery section of the AMA's coding book** and is subject to Global or Surgical rules regardless of whether these services were provided at the hospital or in the office.

An insurance claim for Fracture Care will typically appear as follows:

- An **Exam** (99200 code series) for diagnosis and decisions about the best treatment options.
- An **X-Ray** (70000 codes) is used to diagnose the fracture. Even if you bring x-rays with you, additional views may be required and are separately billable. A post fracture treatment x-ray may be taken to ensure proper alignment of the fracture has been maintained.
- A **Fracture Code** (20000 codes) will be assigned based on the site, type of fracture and whether the treatment is open or closed. Open treatments are performed in the Operating Room at the hospital or outpatient surgery facility. Closed treatments may be done in the office with casting. However, all fracture treatment is considered "major surgery" by the Federal (CMS) and AMA coding systems and will oftentimes be reported as surgery on your insurance company's "Explanation of Benefits" (EOB).
- The **Initial Cast Application** (29000 codes) is included in the above Fracture Code at no charge. Subsequent applications are separately reportable and billable.
- **Casting Supplies** are reported and billed separately
- **Subsequent Fracture Care**: Most "routine" fractures will require several post-operative/follow-up visits which are included at no charge in the original fracture/surgical fee if related to the same diagnosis. The postoperative/global days are standardized by diagnosis code. Subsequent x-rays, cast applications, and supplies are NOT covered under the global period and are billable.

Some of the more serious types of fractures may need additional surgery or procedures. There are special rules and modifiers our office is required to use to report those services.

This office is required by the Federal Compliance laws to report the services provided based on the documentation in the medical record. We cannot improperly alter a claim for the purpose of obtaining payment, nor can we discount patient co-pays and deductibles. If you discover a bona fide billing error, duplicate charge, or other posting error, we would greatly appreciate bringing the matter to the attention of our Billing Department for further investigation and proper corrective action if appropriate.

As you know, coverage and payment amounts vary greatly by insurance company. If you have any questions about your particular coverage, it is best to check with your company's representative or insurance carrier. Our Billing Department staff will be happy to assist you in the claims process for prompt adjudication and payment for your insurance claim. Remember that insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rest with you.