FRACTURED FAIRY TALES ABOUT FRACTURES!

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Objectives

- What is a “fracture”
- Different types of “fractures”
- Closed “fractures”
- Open “fractures”
- “Fracture” care
- Ethics
- Medicare Guides
- Modifiers
- Closed Treatment
- Closed Treatment with manipulation
- Percutaneous Pin fixation
- Open Fracture
- Casting/splinting

FRACTURE TYPES

- Transverse
- Oblique
- Spiral

- Angulated
- Displaced
- Angulated & displaced
The restoration of a body part to its original position after displacement, such as the reduction of a fractured bone by bringing ends or fragments back into original alignment. The use of local or general anesthesia usually accompanies a fracture reduction. If performed by outside manipulation only, the reduction is described as closed; if surgery is necessary, it is described as open.

Closed reduction: the manipulative reduction of a fracture without incision.
Open reduction: reduction of a fracture after incision into the fracture site.
 Toe Fracture
Intra-articular

Intra-articular fracture of the interphalangeal joint, great toe.
Closed reduction with Percutaneous pin fixation

ICD-10 Glimpse......

- A=Initial encounter for closed fracture
- B=Initial encounter for open fracture type I or II
- C=Initial encounter for open fracture type III
- D=Subsequent encounter for routine healing
- E=Subsequent encounter for open fracture type I or II routine healing
- F=Subsequent encounter for open fracture type III routine healing
Fracture Global Care

- There are two common approaches at this time that can be used when coding nonmanipulative fracture care services. The American Academy of Orthopaedic Surgeons (AAOS) and the American Medical Association (AMA) support these two approaches. The AMA has published several articles in the CPT Assistant to reflect how these options work. The two common approaches/methods are:
  - Fracture global fees
  - Alternative method for fracture fees

In the AAOS Guide to CPT Coding for Orthopaedic Surgery, the definition of fracture global fees reporting method states:

Fracture global fees may include the hospital/office encounter in some payment areas. In others, CMS allows you to code an E&M service with a —57 modifier within the global period if the visit was the one in which the decision to perform the procedure was made.... The initial cast is applied, and all revisits, excluding radiographs that are obtained by the physician, should be included within a 90-day period from the time of the initial fracture. All recastings are on an ‘encounter’ basis and are billed separately.

Here’s the AAOS definition of the alternative method:

Only when treatment of the fracture does not consist primarily of a ‘procedure’ (for example, closed treatment without manipulation), services may be itemized as if the problem were recognized as an office encounter. Examples include an undisplaced fracture of the fifth metatarsal; a fracture of the pelvis, undischaced or minimally displaced; or a compression fracture of a vertebra. Office, hospital, and emergency department encounters are coded as appropriate, as are all injections, supplies, casts, or treatment program necessities....
Open Reduction Internal Fixation with plates and screws

Billing

OV, X-ray, cast application, supplies

vs

Global package, 90 day follow-up
No initial cast application.

Good, bad, indifferent?????
Business Decision

You need to decide if the RVU value for itemized billing outweighs the global package.

Scenario

What if a patient comes into your office with a fractured clavicle. It is not displaced and has good position. The patient is given a sling and told to follow up PRN.

What should be charged? Can the office bill fracture care? Why and why not?
Fracture care

SPLITTING FEES

WHEN SHOULD IT BE DONE?

DOES IT HAPPEN?

Physician Reimbursement

Approximately

17% pre-operative

63% operative

20% post-operative
Fractured Femur
The patient was injured on the slopes of Aspen and lives in New Jersey. Has surgery in Aspen, but then goes home. Who should get the $$$$?

What questions on this situation arise? What is the right thing?
### Modifiers

If the surgeon knows that the patient is not staying for post-op care. They should apply modifier -54 (surgical care only).

There should be a phone call and or written documentation from the performing surgeon to the orthopedist in a transfer of care.

The orthopedist accepting care should bill same surgery code with modifier -55 (post-operative).

### CMS 1500

If you are the treating physician and you are billing for pre and intra-operative care you must put the DOS on the from/to date service line.

If you are billing for transfer of care for fracture care...the physician accepting the transfer must put the date seen.
Left-Intramedullary rod

Right-plate and screw fixation
What if the patient is seen by another physician in your practice during a global period...

Or...

If it was a closed reduction without manipulation, which fee alternative did you use?
References

- AAOS Complete Global Service Data for Orthopaedic Surgery 2011
- CPT changes 2011 - AMA
- AMA Category III codes
- Video clip "Fractured Fairy Tales, retrieved from youtube
- Video clip "Skiing Montague", retrieved from youtube