Fracture Management

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OBJECTIVES

- Fracture coding, what do you need to know?
- Types of fractures
- Types of treatment
- “Fracture care”
- CCI guidelines w/2013 changes
- ICD-9 diagnosis guidelines
- A glimpse at ICD-10
This presentation is for education purposes only. The information presented is not intended to be legal advice. The information presented was current at the time presented and when applicable, based upon guidelines published by the AMA, CMS, and NCCI.
What Do You Need To Know Before You Code?
Fracture definition
Location
Configuration
Alignment
What Is A Fracture?
“A break or disruption in the continuity of a bone, epiphyseal plate or cartilaginous surface”

Blauvelt & Nelson
In Other Words, A Broken Bone
Location

- The specific bone(s) involved
- Where on the bone
Anatomical Terminology

- Epiphysis - bulbous proximal or distal end of a long bone
- Metaphysis - section of bone between the epiphysis and diaphysis of a long bone
- Diaphysis - shaft of long bone
- Physis - growth plate
Open vs. Closed FRACTURE

- Open fracture shows communication of the fracture with the outside environment
- Simple puncture wound to massive open near amputation
- The bone can produce the opening or the opening can produce the fracture
Open vs. Closed Fracture

- Closed has no break in the skin that communicates with the fracture.
Open wound ≠ Open fracture

The key: do the fracture and the wound communicate with each other?
Common Fracture Types

- Articular=intracapsular
- Avulsion
- Greenstick-kids
- Torus-kids
- Occult
- Pathologic
- Stress
- Numerous other types with no correlation to ICD or CPT codes
Common Fracture Configurations

- Comminuted-more than two pieces
- Compound-open
- Oblique-diagonal
- Segmental-several large non-adjacent fx in same bone
- Spiral-twisting fracture; also called torsion fx
- Transverse-fracture across the shaft
Type of Treatment

- Closed - two methods
- Open
- Percutaneous skeletal fixation
Type of Treatment....

- Type of manipulation
  - Defined by CPT as the *attempted* reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces

- Type of stabilization
  - Internal
  - External
    - Pins and frame
    - Cast/brace
  - Percutaneous
Type of Treatment

Open

- Fracture is visualized
- Internal or external or no fixation
  - Sometimes both
  - Internal fixation can be placed percutaneously
- ≠ Open FRACTURE
Type of Treatment
Open

- IM (intramedullary) rodding
  - Bone is opened remote from the fracture site
    - Rod is placed down the intramedullary canal
    - Often screw fixation is placed at the proximal and distal ends to prevent movement of the rod
  - Fracture is visualized only by x-ray
  - If no CPT code descriptor for IM rodding should be coded as open
    - CPT Musculoskeletal System Chapter guidelines
Type of Fracture
Open

- If open fracture was debridement performed?
  - Debridement of open fractures 11010-11012 NOT 11010-11044
    - Also for debridement of open dislocations
    - Includes exploration of the wound
  - Debridement of open fractures can be repeated/staged
    - Continue to report with 11010-11012 until definitive management of the fracture performed
    - Attach 58 modifier
    - Once fracture has been treated and treatment is directed at management of the wound report
  - Can be reported multiple times on same claim if different fractures and/or different levels of debridement
    - Mod 59
Debridement is more than washing/irrigating with “copious amounts” of antibiotic solution

Documentation is the key
- The level of tissue debrided
- Debris or other “junk”
- Wound may or may not be closed

Described in CPT as extensive, intensive
Type of Fracture
Open

- An OPEN fracture can be treated CLOSED with or without reduction
Type of Treatment
Percutaneous Skeletal Fixation

- Treatment is neither open nor closed
- Fracture fragments are not visualized
- Device is inserted through the skin with a minimal incision
  - May be seen with open treatment
- Usually done with imaging (fluoro, C-arm)
  - Use of imaging during the procedure is included in the procedure
Type of Treatment Closed

- Manipulative reduction
  - In other words, did the physician push on the fracture to reposition the bone
  - Sometimes this is done when the cast is applied
- Cast application with “molding”
- Wedging of cast
- Look for post-reduction/casting x-rays
Type of Treatment
Closed

- Closed management or “Fracture Care”
- In other words, no reduction
Non-Manipulative Fracture Care
With a few exceptions, if it is broken and a treatment/procedure is performed bill for the global service of management of the fracture
Fracture Care
The Rule of Three

Rule #1
- Confirmed fracture diagnosis
  - ≠ Possible, probable, maybe, appears to be
Rule #2

- Institution/continuation of treatment
  - NOT ALL FRACTURES WILL BE TREATED WITH A CAST
  - i.e. stabilization of the fracture
  - Orthoses such as CAM walkers, Sarmiento sleeve
Fracture Care
The Rule of Three

Rule #2

- Institution/continuation of treatment
  - Fractures such as the proximal humerus, scapula, radial head and neck and clavicle cannot be immobilized in a cast
  - Standard of care is treatment in a sling
Rule #3

- Planned follow up
Fracture Care

- If plan is for manipulative procedure at a future date, non-manipulative fracture management should not be billed.
- If treatment is instituted, with the possibility for a manipulative procedure at a future date, bill non-manipulative fracture management.
  - Determination of subsequent procedure is dependent upon maintenance of fx position w/o addl treatment.
  - Addl procedure will require -58modifier.
Fracture Care
Exceptions

No one’s rule

- Phalangeal fractures treated w/buddy taping
- Pelvis fracture (excluding acetabulum)
- Metatarsal fracture treated with a stiff soled shoe
Fracture Care Exception
Vertebral body fractures

CPT 22310
“Closed treatment of vertebral body fracture(s) w/o manipulation, requiring and including casting or bracing”
Fracture Care Exception
Vertebral body fractures

CPT 22310

Per the AMA CPT Assistant June 2006, Volume 16, Issue 6, page 16

“In order to report the casting or strapping codes, the procedure must be performed by a physician or by other personnel under the direct supervision of a physician. As direct supervision indicates, the physician MUST BE PRESENT DURING THE PROCEDURE when a nonphysician is performing the splint application”
Fracture Care Exception
Vertebral Body Fractures

CPT 22310

What does this mean?

If the orthotist applies a TLSO (back brace) without the presence of the physician, no fracture care can be billed.
Fracture Care vs. Itemized?

- In general, reimbursement is nearly equal for fracture management vs. E&M
  - Initial cast application cannot be billed with fracture management, may be billed with E&M
  - Subsequent casts may be billed for both
  - Cast materials can be billed for both
  - X-rays can be billed for both
  - E&M cannot be billed for either situation if the primary reason for the visit is a cast change (-25 modifier criteria)
Fracture Care vs. Itemized?

The bottom line……

THERE IS NO WRITTEN RULE

- The decision to bill fracture care vs. itemized is ultimately an internal business decision
- Suggest development of policies so that all coders/physicians are consistent
- CMS is reviewing global period
- CMS does not expect charges for itemized billing to far exceed that of global fx care
Fracture Care vs. Itemized?

If decision is to bill global fracture care, make sure patient is informed.
Non–Manipulative Fracture Care 2013 CCI

January 1, 2013 Manual Revision

“If a cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture without manipulation CPT code may be reported.”
Non-Manipulative Fracture Care 2013 CCI

Written inquiry response February 8, 2013

“This policy is applicable to any combination of multiple bone fractures treated with the same cast, strapping or splinting and without manipulation. It is NOT limited to multiple fractures of the same type of bone (e.g. metacarpals, carpals). There is a single 90 day global period applicable to these multiple fractures which includes all the post-operative evaluation and management services related to the closed treatment of the fractures without manipulation.”
Further response

- Includes non-manipulative management when any additional fracture may be treated with either closed or open reduction and all fractures will be treated with the same immobilization device.
Fracture Care and E&M

- Per AAOS, AMA and CMS the initial evaluation for treatment and diagnosis of the fracture is billable with a 57 modifier.
- Just because treatment doesn’t involve slicing and dicing doesn’t mean the same thought process and risk management isn’t involved.
- All fracture treatment codes currently carry a 90 day global period and are therefore considered a major procedure.
Fracture Care and the ER/UC

- If ER/UC physician makes the diagnosis and applies a splint, the ER/UC physician should bill only for the E&M and splint application

**WHY?**

No definitive treatment is being provided
The ER/UC physician is not assuming care for management of the fracture and the results

This is supported by CMS and the AMA
Fracture Care and the ER/UC

CPT introductory guidelines state:

“If a cast application or strapping is provided as an initial service 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 in addition to an evaluation and management code as appropriate.”
Fracture Care and the ER/UC

- If ER/UC physician makes the diagnosis and performs a reduction, the ER/UC physician should bill the fracture management code with the 54 modifier unless the ER/UC physician provided a significant portion of the post operative care.
- Ortho would bill the fracture management code with 55 modifier or for some payors, E&M, subsequent casting codes.
  - There must be a written transfer of care from the ER (or other physician) and ortho must accept the transfer of care.
  - Claim must note the date the receiving physician assumed care (Box 19).
Fracture Care and the ER/UC

- Reimbursement with the 55 modifier equals the post operative portion of the fee schedule or approximately 20% of the allowable
Cast/Splint Application

- Fracture management, regardless of type is considered a major “surgery” with a 90 day global period.
- Application of the initial cast/splint (not orthosis) is ALWAYS included when billing any form of fracture management
  - Application of an orthosis is not considered application of a cast/splint and should be billed with the appropriate L code only
- Per CMS and AAOS, supplies are not included in the cast application or management of the fracture
Cast/Splint Application

- Although by definition, cast applications fall outside of the global period, Medicare requires a 58 modifier on all subsequent cast applications during the global period.
- Why? Cast application codes have a zero day global period.
Effective July 1, 2001, A4570, A4580 and A4590 are no longer valid HCPCS codes
- 51 Q codes were established for cast supplies
Each Q code includes all of the materials needed for application of the cast with the exception of waterproof cast padding (Gortex/Procel, Delta lite).

- You should not be billing for multiple units/multiple rolls of material, padding, stockinette, etc..
Cast/Splint Application Q Codes

- Type of cast applied
  - Short arm, long arm, short leg, etc.
- Type of cast material
  - Fiberglass/synthetic or plaster
- The age of the patient
  - Pediatric = age 10 and under
Cast Supplies Q codes

- Q4006 long arm cast, adult fiberglass
- Q4008 long arm cast, pediatric, fiberglass
- Q4010 short arm cast, adult, fiberglass
- Q4012 short arm cast, pediatric, fiberglass
- Q4030 long leg cast, adult, fiberglass
- Q4032 long leg cast, pediatric, fiberglass
- Q4038 short leg cast, adult, fiberglass
- Q4040 short leg cast, pediatric fiberglass

*Not all inclusive*
Cast Supplies
Gortex/Procel

- Q4050
- Description of supply must be on claim
  - “waterproof cast padding short arm cast”
- Some healthplans will want an invoice
- Some Medicare carriers cover only if documentation of medical necessity others do not cover and consider provider responsibility
- Some healthplans do not cover and require ABN to bill patient
**Stress/Pathologic Fractures**

- As long as the documentation supports fracture management treatment can be considered fracture management.
Dislocations, Sprains and Strains

- A dislocation is never treated without a procedure being performed
- There is no CPT code for medical management of a sprain/strain
  - E&M and cast application if performed
  - 25 modifier criteria must be met
Fracture–Dislocation

- If both a fracture and dislocation of the same anatomic site and if both are treated, bill only treatment of the fracture unless there is a combination code (eg. Monteggia, Galeazzi)
- If initial treatment is reduction of the dislocation then separate session for reduction of the fracture, bill the appropriate dislocation reduction code followed by the appropriate fracture reduction code with a 58 modifier
Malunion–Nonunion

- When available CPT selection should be for repair nonunion/malunion not osteotomy
- If no malunion/nonunion CPT code available, may use fracture treatment code for nonunion repair and generally osteotomy code for malunion repair
Per ICD-9 Guidelines and AHA Coding Clinic the 800 series code should be used when the patient is receiving active treatment for the fracture.

Active treatment includes surgical treatment, emergency department encounter, evaluation and treatment by a new physician.

800 series code may be assigned if the patient undergoes a subsequent procedure related to management of the fracture.

- Initial closed reduction followed by ORIF
Aftercare V codes should be assigned for subsequent visits following active treatment of the fracture

V codes should be assigned for routine care during the healing or recovery phase

V54.1x assigned to traumatic fractures

V54.2x assigned to pathologic fractures
Diagnoses ICD–9

- Fracture-dislocation-per AHA Coding Clinic Quarter 3 1990 when documented as fracture-dislocation only the fracture ICD-9 should be assigned
  - Dislocation is listed as a non-essential modifier under fracture
Nonunion/Malunion 733.8x relate to nonunion/malunion of fractures only
- Append late effect fracture 905.2-5 to clarify where the original fracture was
- No specified time frame for non-union; should be assigned per physician documentation
Diagnoses ICD–9

- Multiple fractures should use multiple diagnosis codes in order of severity of injury
Diagnoses

- Pathologic fracture involves an underlying disease process
- Stress fracture is due to repetitive activity with no trauma
ICD–10 and Fractures

- Specificity for right and left
- Non-union, malunion, delayed union now attached to a specific fracture
- Specificity for displaced vs. nondisplaced
- 7th digit specificity for initial and subsequent encounters, healing vs. delayed vs. nonunion vs. malunion
- Extensive expansion of fracture classifications
- Open fracture classifications based upon Gustillo classification system
- Initial fracture category carried throughout course of treatment
Thank You

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