Prevent improper insurance denials using LogixHealth Denials Intelligence.
Emergency physicians provide important and meaningful fracture care on a regular basis. Although a lot of myth and mystery surrounds the reporting of fracture care services in the ED, a few simple concepts help to greatly simplify things. In order to report fracture care services, the Emergency Physician must either manipulate the bones (so called restorative care) or for those fractures where manipulation is not clinically indicated, they must provide the same treatment as the orthopedist (so called definitive care).

**Restorative Care Example:** A 70-year-old female presents after a fall on an outstretched arm. An x-ray shows a dorsally displaced distal radius fracture, a “Colles fracture.” The Emergency Physician performs a hematoma block and reduces the fracture. The physician has performed a manipulation (restorative care). In this case you would report the code for closed treatment with manipulation of a distal radius fracture (CPT 25605).

Many ED physicians perform fracture manipulations for displaced fractures such as:

- Finger Fractures
- Toe Fractures
- Metacarpal Fractures
- Metatarsal Fractures
- Distal Fibular Fractures
- Bimalleolar and Trimalleolar Ankle Fractures
- Distal Radius Fractures

Remember to write a procedure note when performing these manipulations so the coder can capture these high RVU procedures.

**Definitive Care Example:** A 28-year-old male slips in the bathroom striking the right side of his chest on the edge of the tub. An x-ray shows non-displaced fractures of ribs 7 and 8. The Emergency Physician treats the patient’s pain, reviews expected progression of symptoms, healing, potential for complications, and orders an incentive spirometer to prevent secondary pneumonia. The patient is ultimately discharged with a prescription for narcotics. The Emergency Physician did not perform a manipulation of the bones therefore a manipulation code would be inappropriate. However, the care provided was the same care that a “specialist” would have given, i.e. definitive care was provided. In this case you would report 2 units of the code for closed treatment of rib fracture (CPT 21800).

Many ED physicians provide **Definitive Care** for fractures such as:

- Finger Fractures: 26720, 26750
- Toes Fractures: 28490, 28510
- Clavicle Fractures: 23500
- Rib Fractures: 21800

These are high RVU procedures and should not be overlooked.
LogixHealth provides expert ED Chargemaster evaluations and maintenance services.
Fractures are the result of high energy injuries and warrant a thorough evaluation of the mechanism of injury, distal neurovascular status, and a screening for other injuries. As such, an E/M will typically apply. Be sure to document a thorough H & P. These cases typically involve prescription drug therapy, and tend to be high level cases, often 99284 or above.

See LogixHealth's Documentation Manual for a full review of E/M documentation. To request a copy of the LogixHealth Documentation Manual, please visit our website at logixhealth.com.

Splints

If the fracture care code is being reported then a separate splint code should not be added. However, if the ED physician applies a splint, but does not meet the requirement for definitive or restorative fracture care, then the splint code would be reported. For instance, if the patient has a non-displaced distal radius fracture which is placed in a volar short arm splint in the ED, and the orthopedist will place a cast in several days, then the splint code should be reported. Common splinting procedures performed by ED physicians include:

- Finger: 29130
- Short Arm: 29125
- Long Arm: 29105
- Short Leg: 29515
- Long Leg: 29505

Modifiers

For many fractures the follow up care will likely be provided by an orthopedist and the -54 modifier is added to the fracture care code. This shows that the ED physician provided the preoperative and operative care but will not be performing the follow up. When the -54 modifier is used with the fracture care code, the ED physician generally garners 70% of the revenue associated with the fracture care service. Since the fracture care codes represent Medicare major procedures with a 90 day global, the -57 is appended to the E/M code for Medicare patients.

Fracture Care Vignette

A 25-year-old male crashes his bicycle. He suffers no loss of consciousness or neck injury and presents complaining of shoulder pain with some road rash. Following clearance of his cervical spine a full exam reveals a tender shoulder with soft tissue swelling and pain over the clavicle. X-rays revealed that the patient has suffered a clavicle fracture. The physician prescribes pain medication, discusses the expected progression of healing, the options for follow up and the signs and symptoms for the patient to monitor. The patient is ultimately discharged. The following codes are assigned: 99284 (approximately 3 RVUs) and 23500-54 for the clavicle fracture which carries an additional 6 RVUs.

Definitive care can involve treatment of pain, provision of discharge instructions, and in some specific cases, stabilization of the injury. If the patient has a finger fracture and the definitive care that would be provided by the orthopedist is placement of a finger splint, then in that specific case placement of the splint may represent definitive care and be reported with the fracture care code. However, if the orthopedist would normally place a cast, such as for a distal fibular fracture, but only a splint was placed in the ED, fracture care would not be reported.
If I sedate the patient to reduce a fracture, or perform Moderate Conscious Sedation, should I report the fracture care codes that carry the term “with anesthesia”?

No. Although the CPT manual itself does not have a specific description of when to apply the “with anesthesia” codes, written correspondence from AMA personnel has stated that “with anesthesia” refers to procedures performed in the Operating Room. The additional significant RVUs applied to the codes carrying the term “with anesthesia” reflect the extra effort involved in the formal OR process such as stand by time for OR preparation, scrubbing, induction of anesthesia, and other OR processes.

Is it acceptable to bill for x-ray readings if I am also providing fracture care?

Yes. As long as you have met the documentation requirements for the x-ray reading service there is no prohibition against the same physician billing for both x-rays and fracture care. CPT specifically lists the subcomponents that are considered bundled with surgical procedures, which include local infiltration and metacarpal/digital block. Radiology services are not listed as being bundled.

Is there a difference, from a coding perspective, between open and closed fracture treatment?

Yes. Open treatment of a fracture describes a process where a surgical incision is made to reveal the fractured bones as part of the treatment process. Closed treatment is more commonly provided in the ED, and does not involve making a surgical incision. The confusion arises in the treatment of open fractures. Even if the patient has suffered an open fracture, the open fracture codes are only employed if the physician makes a formal incision as part of the treatment process.