Fractures 101
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What, exactly, is a fracture? What are the different kinds of fractures, and how do we treat them or fix them? What are the realities of coding and billing as they relate to fracture care? In this article, we will seek answers to everything you always wanted to know about fractures, but were afraid to ask.

What is a fracture?

Many people believe that a fracture is a “hairline break,” or a certain type of broken bone. This is not true. A fracture and a broken bone are the same thing.

Are there Different Kinds of Fractures?

There are several types of fractures: transverse, oblique, spiral, angulated, displaced, and angulated and displaced (see picture, below).

How Many Types of Fractures Are There?

An exhaustive listing of precise fracture types would fill a book. A few examples include:

- **Barton’s fracture**: Fracture of the distal end of the radius into the wrist joint (ICD-9 813.42).
- **Fissure fracture**: A crack extending from a surface into, but not through, a long bone.
- **Jefferson’s fracture**: Fracture of the atlas (first cervical vertebra).
- **Lead pipe fracture**: A fracture in which the bone cortex is slightly compressed and bulged on one side, with a slight crack on the other side of the bone.
- **Parry fracture/Monteggia’s fracture**: Fracture of the proximal half of the shaft of the ulna, with dislocation of the head of the radius (ICD-9 813.03)
**Ping-pong fracture:** A type of depressed skull fracture usually seen in young children, resembling the indentation that can be produced with the finger into a ping-pong ball; when elevated it resumes and retains its normal position.

**Pott’s fracture:** Fracture of the lower part of the fibula, with serious injury of the lower tibial articulation, usually including chipping of the medial malleolus, or rupture of the medial ligament.

**Colles’ fracture** A fracture of the lower end of the radius, with the lower fragment being displaced backward; if the lower fragment is displaced forward, it is a reverse Colles’ fracture (ICD-9 813.41).

These above are just a few fracture types. The list goes on, and on, and on... To help with coding, when reviewing documentation dealing with fractures, have a medical dictionary or other resource on hand to look up unfamiliar terms.

**How Do You Fix Fractures?**

Generally, bones heal best when immobilized; therefore, treatment often involves casting of the broken bone (or fracture) and may require surgery to fix the bone into place. Prior to casting or fixation, the broken bone(s) must be returned to its proper position. This is referred to as “reduction.”

“Closed” reduction is manipulation of a fracture without an incision. “Open” reduction, by contrast, refers to manipulation of a fracture after incision into the fracture site. When coding for fractures, you will need to know the type of reduction used, as well as which body part is affected (i.e., leg, arm, finger, foot, etc.) and, in some instance, the precise location of the fracture is (for instance, does the fracture affect the head or shaft of the femur).

As an example, consider the X-ray images, below. Each describes a different type of fractures and fracture reduction.

![X-ray images](image)

The X-ray on the left reveals a fracture on the third or long finger proximal phalanx (816.01 Closed fracture of middle or proximal phalanx or phalanges of hand). This fracture is minimally displaced, and could be an example of a closed treatment of a phalangeal fracture (CPT® 26720 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each) or closed treatment with manipulation (26725 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each), depending on what the provider documents.
On film A, the short arrow shows a displaced fracture of the index finger (816.01), while the long arrow on film A shows multiple finger metacarpal fractures (815.03 Closed fracture of shaft of metacarpal bone(s)).

Film B short arrow shows a percutaneous pin fixation (short arrow, CPT® 26727 Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each), and internal fixation with plates and screws (long arrow, 26615 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone). There are types of internal fixation for fractures, as well, such as rods and spheres.

**How Do We Bill Fracture Fees?**

There are two common approaches when coding non-manipulative 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 options are:

1. Fracture global fees
2. Alternative method for fracture fees

The AAOS *Guide to CPT Coding for Orthopaedic Surgery* definition of fracture global fees reporting method states:

Fracture global fees may include the hospital or office encounter in some payment areas. In others, CMS allows you to code an E/M (E/M stands for “evaluation and management”. E/M coding is the process by which physician-patient encounters are translated into five digit CPT codes to facilitate billing) service with a -57 modifier [Decision for surgery] within the global period if the visit was the one in which the decision to perform the procedure was made. The initial cast or splint 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 and or splinting are on an “encounter” basis and are separately billed.

Here is 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, undisplaced 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, splints or treatment program necessities.

Be aware that this guidance is payer specific: When fracture care is performed in the office, the payer may want you to append modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service to the E/M service.

Your practice must decide whether to bill for treatment of a fracture or to itemize depending on your scenario.

**Coding example:** Closed reduction without manipulation vs. E/M

If you report closed reduction w/o manipulation
Cast/splint/strapping is included
X-ray and supplies may be separately reported

If you report an E/M service
Cast/splint application, X-ray and Supplies all may be separately reported

The closed reduction, if you report it, includes a 90-day global package. The first casting, splinting, and strapping are included in the procedure, along with all post-op visits. Global treatment excludes X-rays, any durable medical equipment, and any casting/splinting supplies, all of which must be reported separately. The global package means that you are not allowed to charge for the post-operative portion of the procedure. In simple terms you cannot charge for an office visit until after the global period.

In such a case, proper coding would be:

• Procedure: 26725 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation, with or without skin or skeletal traction, each

Do not code separately for cast or splint application.

• Next visit: 99024 Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure

• You cannot charge separately for related E/M services during the 90-day global period.

• You may report casting and/or splinting supply charges according to documentation.

In another example, a patient comes into your office with a fractured clavicle. The fracture is not displaced and has good position. The patient is given a sling and told to follow up PRN (as needed). Can the office bill fracture care? Is this considered treatment if patient is not to return?

Remember: When charging for a fracture care code (or any surgical procedure), there is a formula that includes pre-operative, operative, and postoperative portions.

**Physician Reimbursement (approximate)**

- 17 percent pre-operative
- 63 percent operative
- 20 percent post-operative

In the example above, there is no intent that the provider will be following up with the patient; which eliminates the post-operative portion of the formula. The argument could be made that billing the fracture treatment code would be incorrect. For instance, if an emergency department (ED) physician treats a fracture with no intent to follow-up with the patient, it would be incorrect to bill fracture care codes. Rather, you would report an appropriate E/M service.

Let’s consider a different scenario on using fracture codes and how the reimbursement varies using the formula. A patient was injured on the slopes of Aspen and lives in New Jersey. He has surgery in Aspen and returns home, where he receives follow-up care. What happens to reimbursement?

Ideally, the surgeon in Aspen should get the 17 percent pre-operative portion and the 63 percent operative or surgical portion. If the surgeon knows that the patient is not staying for post-op care, he should apply modifier 54 **Surgical care only** to the billed fracture care code. He should place a phone (and provide written documentation) to the patient’s orthopedist in New Jersey to transfer care. The orthopedist
accepting care should bill same surgery code with modifier 55 Post-operative care. The accepting orthopedist would receive 20 percent or the post-operative fee.

In the real world, the billing is almost never ideal, as described above. What surgeon wants to give up 20 percent of his surgery fee? What physician wants 20 percent payment to treat someone else’s work? In working in orthopedics for 25 years, I have not ever seen this happen. What can one do if faced with this similar scenario?

In my opinion, you should make a call to the surgeon in Aspen (or wherever the initial treatment occurred) and plead your case. If the surgeon has already filed a claim, but agrees to split the fee, a corrected claim would need to be filed. But if there is no phone call placed with no documentation stating the transfer, you cannot bill for the post-operative care.

Bio
Cynthia Everlith, BSHA, CPC, CMA, is practice administrator for Arizona Hand and Wrist Specialists, a division of OSNA, PLLC. She has 25+ years of experience in orthopedic coding and practice management and 16 years with her current practice. She is actively involved in legislation with respect to Workers Compensation and has worked closely with the Industrial Commission of Arizona and the Arizona Medical Association in rules affecting physicians. She has presented both nationally and locally with her physicians. She is a past Board of Director for the AAOE (American Association of Orthopaedic Executives) and past president of the Grand Canyon coders Phoenix chapter of the AAPC. She is currently serving on the AAOE Communication Council and Technology Task force and is president of the Ariz. AAOE chapter.

Quiz Yourself

1. What can be considered a fracture?
   a. Crack in the bone
   b. Bone sticking up through the skin
   c. Chip in the bone
   d. All of the above*

   Rationale: Many people believe that a fracture is a “hairline break,” or a certain type of broken bone. This is not true. A fracture and a broken bone are the same thing.

2. Which E/M code would be used for the immediate follow-up visit after a surgical repair of a fracture with a 90-day global period?
   a. 99213
   b. 99024*
   c. 99203
   d. 99243

   Rationale: You may not charge separately for a related E/M during the global period; therefore, the proper code is 99024 Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure.