Documentation Requirements for Billing Closed Fracture Care

There has long been confusion on how to code and/or audit closed fractures. First we need to define the key difference between a "closed" fracture and an "open" fracture. A closed fracture is when a bone breaks but there is no puncture or open wound of the skin. An open fracture on the other hand is one in which the bone has broken the skin in at least one place. According to CPT®, "*The type of fracture does not have any coding correlation with the type of treatment.*" This means that a patient could sustain a closed fracture that requires open treatment. An auditor should always pay careful attention to the operative note to determine the type of fracture first and the type of treatment second.

A closed fracture may or may not require manipulation (*attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied forces*). Closed fractures allow providers to report their respective services in one of two ways. First, the provider may elect to report an evaluation and management code (E&M) for a new patient visit, established patient visit, etc. along with a fracture care code with modifier 57 (decision for major surgery) appended to the E/M code. Applicable supplies are separately reportable. This is called the "global" billing method and will place the patient in a 90-day global period during which related E/M services are not separately reportable. Supplies, subsequent cast applications and imaging services are not included in the "global" fee. Many prefer the "global" method for billing closed fracture care because they are not required to select the correct E/M levels during the post-operative period. Rather, they can report CPT code 99024 (post-operative visit) which has no relative value units (RVUs).

The other option that a provider has is to individually report services from the initial patient encounter throughout the fracture care and healing phase. Using this "itemized" approach would allow the provider to report an E/M service along with modifier 25 and the application of the initial cast and applicable supplies. Imaging is also separately reportable both for the initial visit and subsequent visits throughout the healing phase. This may initially appear to be the most financially advantageous solution, but remember that with the "itemized" method, the provider would be responsible for ensuring that each subsequent E/M service is reported using the correct level of service code. Another consideration should be the current bundling edits. When consulting current NCCI bundling policies, E/M services are inclusive to the minor procedures when performed for established patients so for Medicare and other payers following NCCI policies, payment may not be made for the related E/M services during the post-operative period when subsequent cast applications are performed.

This Week's Tip Provided by:

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