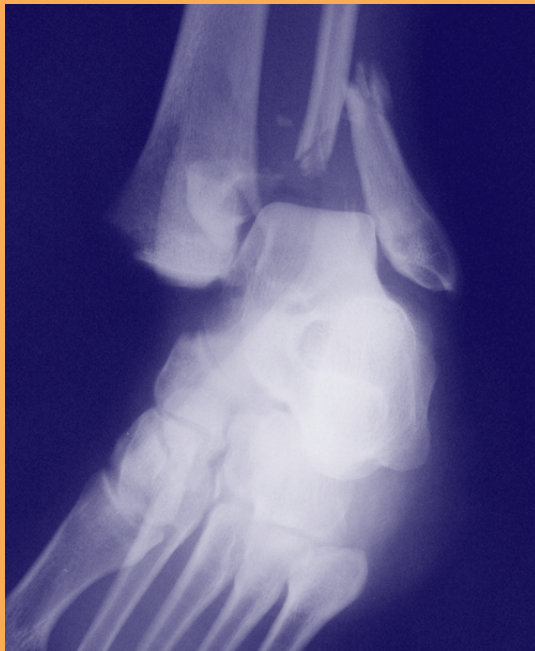




E/M Coding and Reimbursement

Fracture Care



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MRSI Profile

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**).

- Coding over 1 million visits
- All certified coders
- Extensive ED experience
- Rigorous QA processes
- In-house CEU Program

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 25600).

Fracture Care With Manipulation RVUs

Finger Fracture

CPT 26727 - 12.31 RVUs

Bimalleolar Ankle Fracture

CPT 27810 - 11.10 RVUs

Distal Radius Fracture

CPT 25605 - 13.04 RVUs

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 Percocet. 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
- Nasal Fractures 21315

These are high RVU procedures and should not be overlooked.

Fracture Care Without Manipulation RVUs

Finger Fractures

3.96 RVUs

Toe Fractures

2.76 RVUs

Clavicle Fractures

4.91 RVUs

Rib Fractures

2.39 RVUs

Nasal Fractures

3.54 RVUs

E/M With Fracture Care

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 *MRSI Documentation Manual for a full review of E/M documentation.*)

MRSI coders are ED specialized, professional and facility.

To request a copy of the MRSI Documentation Manual, please visit our website at www.MRSInc.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 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 the 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

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 and moderate nasal swelling from an impact on the handlebars. Following clearance of his cervical spine a full exam reveals a tender shoulder with soft tissue swelling and moderate nasal ecchymosis. Shoulder x-rays are negative, but the patient has suffered a non-displaced nasal fracture. The physician prescribes pain medication and decongestants, discusses the expected progression of healing, the options for plastic surgery follow up and the signs and symptoms to monitor for. The patient is ultimately discharged. The following codes are assigned 99284 2.56 RVUs and 21310 for the nasal fracture which carries an additional 3.54 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.

MRSI coders are specially trained using our in-house CEU program

Quiz The Coder

Submit your coding questions at www.MRSIinc.com.

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”?

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 formal OR processes. For a full description of the issues surrounding the new Moderate Conscious Sedation Codes see the MRSI 2006 Coding Update.

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, 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.

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