Fracture Clinic

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Introduction

A certainty every spring is that warmer weather brings green grass, blooming flowers, monkey bars, trampolines and—pediatric fractures! With our trauma clinics starting to fill up, the aim of this installment of the *JPOSNA* "Coding Corner" is to equip you with the most up-to-date knowledge regarding fracture documentation and billing.

The following scenarios highlight general principles that are applicable across fracture patients and also dive deeper into diagnosis-specific issues that pediatric orthopaedic surgeons most commonly face. The purpose is to demystify the different methods of billing for fracture management and provide a roadmap for surgeons to determine the most optimal manner of coding. Although they are not part of CPT, in some cases we've referenced work RVUs (relative value units) set by the Centers for Medicare and Medicaid Services (CMS) in these scenarios.

Scenario #1

Adelyn is a 6-year-old female that fell off her hoverboard sustaining a right, displaced distal radius fracture. She presents to the Emergency Department at the academic medical center where you are an attending. The ED physician performs a conscious sedation and the orthopaedic resident performs a closed reduction and splinting. There is no bill captured for the closed reduction since no attending orthopaedic surgeon or APP participated in the orthopaedic management.

1. *When they arrive at the pediatric orthopaedic surgery clinic at the same institution for the first follow-up, what is the most acceptable method of coding—CPT code or E/M code for a new patient?*

There are two types of closed fracture management codes in CPT—those that do not include manipulation and those that do. If a reduction was performed by the resident without supervision by an attending, KZA does not advise reporting a "with manipulation" global fracture management code when the patient is seen for follow-up because the reduction was performed on a previous date, and supervisory requirements for reporting were not met. We additionally do not advise reporting a "without manipulation" global fracture management code because a reduction was performed, albeit unsupervised and not reportable. KZA instead advises reporting such encounters using evaluation and management (E/M) codes with cast application services where appropriate and allowed for the setting (e.g., office). (In a facility setting, physicians/APPs do not employ and supervise the clinical staff, so cast application is only reportable when it is performed by the billing provider.)

Radiology reporting will vary depending on the arrangements of your practice/institution.

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Doctor's Office Setting (POS 11)	**Hospital Outpatient Setting (POS 19 or 22)**
992XX-25 E/M service	992XX
29075 Application of short arm cast	Cast application by staff is part of facility fees, not reportable by physician
Q4012 Cast supplies, short arm, peds, fiberglass	Cast supplies part of facility fees

If we assume the patient is new to the Doctor's Office Setting and the documentation supports a 99204, the -25 modifier is added to allow additional CPT for application of short arm cast and supplies. The 2021 wRVU total for the first visit would be 99204-25 = 2.6, 29075 = 0.77, and Q4012 = 0. Total wRVU = 3.37.

Alternately, the pediatric orthopaedic practice could report the "with manipulation" fracture management code with CPT modifier 55 to represent the postoperative care only.

For the scenario above, code 25605-55 would be reported:

25605: Closed treatment of distal radial fracture (eg., Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation

Modifier 55: Postoperative Management Only

Payors commonly require that a formal transfer of care agreement be in place between the "operating" physician and the physician assuming care when this format is used. For example, for Medicare claims, CMS requires a written agreement; state-run Medicaid programs may also apply this standard. Under the Medicare program, CMS policy also allows a maximum of 20% of the surgical fee allowable for post-operative care; payment may be adjusted based upon the number of post-operative days managed by the provider.

Example: The 2021 CMS Medicare Fee Schedule (MFS) unadjusted allowable for 25605 in a doctor's office setting is $561.08, and 20% of that amount would be $112.22. By comparison, the 2021 CMS MFS allowable for 99204 in the same setting is $169.93. The allowables in a hospital-based practice would be reduced for the site-of-service.

See https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00101754 for further description. Although Medicare may not be a primary payor for pediatric groups, the reimbursement methodology used by Medicare may be applied by Medicaid and private payors.

2. *Is the billing any different when the fracture is referred from another institution?*

The documentation and coding would be the same if the patient is sent from another institution, such as where reduction was performed by an ED physician.

3. *Let's assume the initial encounter in the ED was staffed by an attending orthopaedic surgeon and captured the CPT code. At the first clinic visit one week after closed reduction and splinting, radiographs demonstrate that the fracture lost reduction and will require cast wedging. Since a CPT code was used initially and this falls within the global period, how does one code for this?*

When a comprehensive fracture code is reported, the service includes 90 days of typical postoperative care. At the same time, under CPT guidelines, cast changes are excluded from the global fracture service. Cast removal is only reportable when it was placed by another physician/group, and the cast is not being replaced. Code 29740 could be reported for wedging of cast (except clubfoot casts) when required to achieve realignment of the fractured bone. Modifier 58 (Staged procedure) would be used to signify that the cast change or wedging is excluded from the global fracture service.

Cast materials are always reportable by the physician/QHP if they are an expense to the practice. For example, in a doctor's office place of service (POS 11),

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cast supplies are purchased by the practice and would be reportable as dispensed/used/documented. In a facility place of service, such as a hospital outpatient clinic (POS 19 or 22), the costs are not typically borne by the practice/department and would not be reportable by the physician/QHP.

4. *Let's assume it's a new patient referred from a pediatrician with a distal radius fracture, never underwent manipulation, is in appropriate alignment upon their first visit with you, and will be treated in a cast. How does a global method of billing compare to an itemized visit?*

Closed mgmt of distal radius, without manipulation, with 4 visits, casted Assumes fracture healed at visit 4				
	Global Method with 4 visits	wRVU	Itemized method with 4 visits	wRVU
Visit 1	99203-57	1.6	99203-25	1.6
	25600	2.78	29075	0.77
Visit 2	99024	0	99213-25	1.3
	29075	0.77	29075	0.77
Visit 3	99024	0	99213-25	1.3
	29075	0.77	29075	0.77
Visit 4	99024	0	99212	0.7
	not re-casted, reduced level of service			
Cumulative wRVUs		5.92		7.21

The use of modifier 25 in the itemized method requires that the E/M documentation meets significant and separate criteria relative to the casting procedure. Casting supplies and imaging may also be reportable, depending upon the practice setting.

5. *How do we bill for fluoroscopy in clinic to check reduction instead of using x-rays?*

A physician may be able to report post-reduction imaging in a setting where the x-ray read is not billed by radiology. If a C-arm is used to perform such imaging, the appropriate radiologic CPT code could be used, determined by the anatomic location and number of views. As a radiology service, the x-ray service must be supported by an interpretation report and images must be retained. If the fluoroscopy unit does not have the capability to save images, the service is not billable. If the practice does not own the radiology equipment, such as in a hospital-based practice, modifier 26 (professional component) must be appended to signify that the physician is only reporting the professional portion of the service.

While CPT does not restrict reporting confirmatory imaging interpretation, payor policy set by CMS does. Specifically, CMS NCCI policy, which is used by state Medicaid plans as well as Medicare, restricts reporting of the professional component of post-reduction images, so if a payor or an institution applies NCCI guidelines, this service would not be reportable at all.

NCCI 2021: Chapter IX, section C, item 3

When a comparative imaging study is performed to assess potential complications or completeness of a procedure (e.g., post-reduction, post-intubation, post-catheter placement, etc.) the professional component of the CPT code for the post-procedure imaging study is not separately payable and should not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.

6. *In the last Coding Corner with E/M changes, we discussed everything as if Pediatric Orthopaedics was not billing for x-ray reads. What would we have to document if we did bill our own x-rays?*

When reporting a radiology interpretation, the physician's documentation should reflect the anatomic location, laterality, the named x-ray views, and findings. For example:

Not Appropriate		Appropriate
Within the body of the E/M note: *2 views of the right wrist appear normal.*	**vs.**	**As a separate report:** ***Study**: Wrist, AP and lateral views* ***Findings:** AP and lateral views of the right wrist show no significant degenerative change and no fracture is noted. There is a mildly positive ulnar variance noted.*

Since 1997, the CPT book has stated: *The physician's interpretation of the results of diagnostic tests with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with the modifier "26" appended*. As such, a separate report is required by CPT when a physician reports a radiology interpretation.

Scenario #2

Luke is a 5-year-old male who was wrestling with his younger brother when he fell and sustained a wrist injury. They present to your pediatric orthopaedic clinic one day later after mom was still concerned his wrist was swollen and he wasn't using that arm much. Radiographs of the wrist demonstrate a distal radius buckle fracture.

1. *How would one document and code for one visit, removable splint applied, and PRN follow-up versus initial visit, cast application, and f/u visit for cast removal? RVU difference?*

There are different options for coding the buckle fracture treated with a cock-up brace versus cast immobilization. For the E/M service, we will assume the patient is new and the documentation supports a low medical decision-making level of service.

Because the physician will not provide the number of follow-up visits valued for closed management code 25600 (*Closed treatment of distal radial fracture (eg., Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation),* we advise that physicians report the service using an itemized method, whether the fracture is treated using a cock-up brace or casting.

a. The use of modifier 25 in scenario B requires that the E/M documentation meet significant and separate criteria relative to the casting procedure. Casting supplies and imaging may also be reportable, depending upon the practice setting.

b. If a physician elected to report global code 25600, it would be appropriate to append modifier (54 Surgical Care only). Modifier 54 is the converse to modifier 55 described in scenario 1: CMS would adjudicate this at 80% of the standard allowable. Although the physician is not performing an open surgery or a closed reduction, code 25600 is a surgical CPT code, and the modifier is appropriate.

Scenario #3 - Lightning Surgical Rounds

1. *For CRPP of a Supracondylar Humerus Fracture, if a 1 cm incision is made to place a medial pin, does*

	1 visit, Cock Up Brace, PRN follow up		2 visits, with short arm casting at the first	
	A		B	
	Itemized method with 1 visit	2021 wRVU	Itemized method with 2 visits	2021 wRVU
Visit 1				
	99203	1.6	99203-25	1.6
	L3908	0	29075	0.77
Visit 2	None	0	99213	1.3
			Not re-casted	
Cumulative wRVUs		1.6		3.67

that constitute an open reduction and a different code?

CPT defines open treatment of a fracture as follows:

> *Open treatment* is used when the fractured bone is either: (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used; or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site (the fracture site is not opened and visualized).

In this scenario an open reduction CPT code for a supracondylar humerus fracture, (24545 or 24546) would only be reportable if the incision allowed direct visualization of the bone ends, and that status was documented. Code 24538 (*Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension)* is used to describe closed reduction and percutaneous fixation even with a medial pin as described in this scenario.

2. *When an indirect reduction is performed through an incision, is that considered a closed or open reduction? Eg.,Kapandje method of reducing a radial neck fracture through a small incision, yet the fracture is never visualized and reduced through direct visualization.*

See the definition of Open treatment above. If the fracture is not directly visualized, then an open treatment code is not reportable.

3. *What is the preferred code for manipulation of a Tillaux fracture with a percutaneous screw placement, 27825 or 27827?*

   Neither 27825 or 27827, but instead 27899—*Other procedures on the leg (tibia and fibula) and ankle joint*. The technique described is percutaneous, not closed or open. Therefore, the preferred code would be 27899 with documentation including the comparison code, 27825 or 27827, and the explanation as to how the work compares. This method is more challenging because it requires an extra explanation, monitoring to ensure the final adjudication is appropriate, and a more complicated method for assigning wRVUs for physician compensation. Despite these drawbacks, an unlisted code in this scenario is the most appropriate answer.

4. *What is the preferred code for reduction of a pediatric femoral neck fracture utilizing positioning and traction followed by percutaneous screw fixation and a capsulotomy to attempt to decrease the risk of AVN, 27235 or 27236?*

   27235 – *Percutaneous skeletal fixation of femoral fracture, proximal end, neck.* Similar theme as the previous examples: no direct visualization of the fracture ends prevents the 27236 (open) code from being chosen. Despite indirect reduction of the fracture and a capsulotomy, the merits of an open reduction have not been met. Percutaneous skeletal fixation is the best option.

Summary

Proper documentation and coding of pediatric fracture patients hinges on the type of treatment and billing that was performed prior to them presenting to your Trauma Clinic. Capture of a CPT code by your department during the initial treatment places the patient in the 90-day global window and future billing is contained within the initial CPT. If the patient is sent from a different ED or institution, then the provider has a decision to pursue coding based on E/M or CPT depending on the diagnosis, treatment, and future number of follow-ups. The two scenarios aimed to detail the various permutations of how these patients may present and the most accurate and complete way to code. Finally, the quick hitters clarify some commonly asked surgical scenarios that our members have faced. Monkey bars, trampolines, pediatric fractures—It is going to be a great spring!

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