THE HAND CENTER

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FRACTURE CARE CODING POLICY

The Hand Center of Western Massachusetts makes every effort to follow the current coding practice for reporting medical services as dictated by the federal government (HCFA-the Health Care Finance Administration) and the American Medical Association (the AMA). The regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of fracture care services.

A fracture or "broken bone" is most often diagnosed by x-ray and can vary greatly in severity and treatment options. However for billing and insurance coding purpose, fracture care is listed in the surgery section of the AMA's coding book and is subject to special Global or Surgical "Package" rules, regardless of whether these services were provided at the hospital or in the office.

An insurance claim for fracture care will typically include as follows:

1) An *Exam* at the documented level for diagnosis and decisions about the best treatment options.
2) An *X-ray* often is used to diagnose the fracture and/or post fracture treatment x-ray to ensure proper alignment.
3) A *Fracture Code* will be assigned based on the site, type of fracture and whether the treatment is closed or open. Open treatment most often is performed in an operating room at the hospital or outpatient surgery facility. Closed treatment often is done at the emergency room or in the office and may be with or without manipulation. However, all fracture treatment is considered "major surgery" by the Federal and AMA coding systems and will often times be reported as surgery on your insurance company explanation of benefits. Being "seen" in the emergency room or your PCP's office does not mean that treatment has been initiated. The initiation of treatment implies follow-up and fracture care will be given.
4) The initial work of applying the cast or definitive splint is included in the above fracture code at no charge. Subsequent applications are separately reportable and billable.
5) *Cast Supplies* are reported separately.
6) *Subsequent Fracture care*: Most fractures will require one or more or follow-up postoperative visits which are included at no charge in the fracture / surgical fee if related to the same diagnosis. The post operative / global days vary anywhere from 10-90 days dependent on the insurance company.

The things that are <u>not included</u> in the package are:

1) X-rays either subsequent, for fracture follow-up, or to evaluate a different diagnosis
2) All casting **supplies (including those used in the first cast or splint)**
3) Any replacement cast application
4) The evaluation and management of any additional problems or injuries
5) The treatment of complications including additional procedures or surgery

As you well know coverage and payment amounts vary greatly by payer. If you have any question about your particular coverage, it is best to check with the telephone number on the back of your insurance company card.