



FRACTURE CARE

Dear Parent or Guardian:

Our Office makes every effort to follow the current coding practices for reporting medical services as dictated by the Federal government (CMS) and the American Medical Association (the AMA). These regulations can be quite complicated and generate many questions. 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 purposes, fracture care is listed in the surgery section of the AMA’s (American Medical Association) coding book and is subject to Global or Surgical rules regardless of whether these services were provided at the hospital or in the office.

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

- 1) An Exam (99200 code series) for diagnosis and decisions about the best treatment options.
- 2) An X-ray (70000 codes) is used to diagnose the fracture. Even if you bring x-rays with you, additional views may be required. A post fracture treatment x-ray may be taken to ensure proper alignment of the fracture has been maintained.
- 3) A Fracture Code (20000 codes) will be assigned based on the site, type of fracture and whether the treatment is closed or open. Open treatments, and closed treatment requiring manipulation of the fracture, are performed in an Operating Room at the hospital or out-patient surgery facility. Closed treatment that does not require manipulation may be done in the office. Some fractures do not require cast application. This care involves review of x-rays and follow-up visits to ensure the fracture is healing appropriately. Please understand this still considered fracture care. However, all fracture treatment is considered “major surgery” by the Federal (CMS) and AMA coding systems and will oftentimes be reported as surgery on your insurance company’s “Explanation of Benefits.” This includes clavicles (collar bones), hands and feet.
- 4) The Initial Cast Application (29000 codes) is included in the above Fracture Code at no charge. Subsequent applications are separately reportable and billable.
- 5) Casting Supplies are reported and billed separately.
- 6) Subsequent Fracture care: Most “routine” fractures will require several post operative visits which are included at no charge in the original fracture/surgical fee if related to the same diagnosis. The post operative/global days are standardized by diagnosis code. Subsequent x-rays (70000 codes), cast applications (29000 codes) and supplies are not covered under the global period and are billable. Some of the more serious type of fractures may need additional surgery or procedures. There are special rules and modifiers our office is required to use to report those services.

This office is required by the Federal Compliance laws to report the services provided based on the documentation in the medical records. We cannot improperly alter a claim for the purpose of obtaining payment, nor can we discount patient co- pays and deductibles. If you discover a bona fide billing error, duplicate charge or other posting error, we would greatly appreciate bringing the matter to the attention of our Office staff or administrator for further investigation and proper corrective action if appropriate.

I have read and understand the above information.

Child’s Name: _____ DOB: _____

Legal Guardian Signature: _____ Date: _____

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