FRACTURE MANAGEMENT

Ruby O’Brochta-Woodward BSN, CPC, CPMA, CPB, COSC, CSFAC
October 6, 2016
AAPC Regional Conference Atlantic City
Clinical Technical Editor Decision Health
AAPCCCCA Representative Region 7
OBJECTIVES

- Fracture coding, what do you need to know?
- Terminology
- Types of fractures
- Types of treatment
- “Fracture care”
- CCI guidelines w/2014 changes
- ICD-10 diagnosis guidelines
DISCLAIMER

This presentation is for education purposes only. The information presented is not intended to be legal advice. The information presented was current at the time presented and when applicable, based upon guidelines published by the AMA, CMS, and NCCI.
What Do You Need To Know Before You Code?
Terminology
Fracture definition
Location
Configuration
Alignment
Type of treatment
FIRST

What Is A Fracture?
“A break or disruption in the continuity of a bone, epiphyseal plate or cartilaginous surface.”

Blauvelt & Nelson
TERMINOLOGY

- **Dislocation** - separation of a joint where two or more bones come together in which the ends of the involved bones are forced farther apart than their normal positions.

- **Subluxation** - partial dislocation of a joint in which the bones are misaligned, but the articular surfaces remain in some kind of contact with each other resulting in some loss of normal joint relationship.

- **Sprain** - injury to a ligament:
  - **Grade 1** - stretched beyond their normal range with some microscopic damage to the fibers but no tearing.
  - **Grade 2** - partial tearing affecting some but not all of the fibers; may have some loss of function and joint laxity.
  - **Grade 3** - nearly complete tear/rupture with gross instability.
TERMINOLOGY

- Fracture - break in the surface of the bone
- Avulsion - joint sprain at the insertion of the ligament to the bone with a piece of bone broken off with the ligament
- Strain - injury to the tendons
LOCATION

- The specific bone(s) involved
- Where on the bone
LONG BONE STRUCTURE

- Diaphysis-shaft
- Epiphysis-expanded section at each end
- Metaphysis-section between diaphysis and epiphysis
- Physis-growth plate
- Periosteum-vascular covering of fibrous tissue attached to outer surface of bone
  - Contains nerve fibers
Bone Markings

Bone Processes

- Apophysis - bony prominence
- Condyle - rounded projection at the end of a bone
  - anchors ligaments
  - articulates with adjacent bones
- Epicondyle - projection on the surface of the bone above the condyle
Bone Markings
Bone Processes

- Head-rounded, usually proximal portion of some long bones
- Neck-narrowed area distal to the head
- Trochanter—one of two bony projections on the proximal ends of the femurs that serve as attachment points for muscles
- Tubercle—nodule or small raised area
- Tuberosity—elevation or protruberance, larger than a tubercle
COMMON FRACTURE TYPES

- Articular=intracapsular
  - Involves the joint
  - Intracapsular of the hip=femoral neck
  - Periarticular=around the joint
- Avulsion
  - Sprain/strain that pulls a piece of bone off
- Greenstick-kids
  - One side of bone is broken, the other side bent
COMMON FRACTURE TYPES

- Occult
  - Clinical signs of fracture but no radiologic evidence at time of initial exam
- Pathologic-involves an underlying disease process; if injury, would not typically result in fracture
- Salter-Harris
- Stress-due to repetitive activity with no trauma
- Torus-kids
  - Buckle fracture
  - Incomplete fracture
  - Caused by a compression injury, one side of bone buckles, other side intact
FRACTURE TYPE

Torus

Greenstick
Salter-Harris Classification

- Relates to growth plate or articular fractures
- Can result in complications w/bone growth
- ICD-10 humerus, radius, femur, tibia
  - 2016 added calcaneus, metatarsal, phalanx (toe)
- 3rd character 9
- Five types
Salter-Harris Classification

- **Type I**
  - Generally in young children when growth plate is thick
  - Mechanism of injury is one of shearing
  - Fracture follows the growth plate, separating the epiphysis from metaphysis
  - Displacement unusual
  - Treated w/casting; healing is rapid 2-3 wks.
  - Generally no reduction
  - Generally no complications
  - ICD-10 4th character 1

- **Type II**
  - Most common
  - Generally occurs after age 10
  - Mechanism of injury shearing or avulsion w/angular force
  - Epiphysis & growth plate are separated from metaphysis
  - Generally required reduction & immobilization
  - If occurs to distal femur or tibia may result in growth deformity
  - ICD-10 4th character 2
Salter Harris II with fibula shaft fracture
**Salter-Harris Classification**

- **Type III**
  - Rare
  - Generally occurs after age 10 when growth plate is partially fused
  - Usually occurs at distal tibia
  - Portion of epiphysis & growth plate are separated from the rest of the epiphysis & metaphysis
  - Poor prognosis unless early accurate reduction
  - ICD-10 4th character 3

- **Type IV**
  - May occur at any age
  - Rare in the hand; most common distal humerus
  - Fracture runs through epiphysis, across growth plate, into metaphysis
  - Requires surgical intervention
  - Poor prognosis unless reduction is perfect & is maintained otherwise growth interrupted
  - ICD-10 4th character 9 other

- **Type V**
  - Uncommon
  - Occurs when end of bone is crushed & growth plate compressed
  - Most common in knee and ankle
  - Limb length inequality & angular deformities common complications
  - ICD-10 4th character 9 other
no wt bearing

Salter-Harris III/Tillaux
S89.132A
S82.432A
Salter-Harris III/ Tillaux

no wt bearing
Salter-Harris III/ Tillaux

no wt bearing
Salter-Harris Classification

- **Pneumonic**
  - **S**-slipped (through growth plate w/”bone” involvement)
  - **A**-above (through growth plate up into metaphysis)
  - **L**-lower (through growth plate and down into epiphysis)
  - **T**-through (through metaphysis into epiphysis=intraarticular)
  - **R**-ruined/rammed (crushed)
Salter Harris Classification
COMMON FRACTURE CONFIGURATIONS

- Bent bone-bone is bent creating multiple tiny fractures
  - Also called plastic deformation
  - Not seen on x-ray

- Burst-fracture of vertebra caused by high energy axial load. Traumatic and may be the result of auto accidents or falls from height or high speed

- Comminuted-more than two pieces

- Compound-open

- Compression-crumbling or smashing of cancellous bone by forces acting parallel to the long axis of the bone; applied to vertebral fractures

- Impacted-fragments are telescoped into each other
COMMON FRACTURE CONFIGURATIONS

- Oblique-diagonal
- Osteochondral-break or tear of the articular cartilage along with a fracture of the bone
- Segmental—several large non-adjacent fx in same bone
- Spiral-twisting fracture; also called torsion fx
- Transverse-fracture across the shaft
SPIRAL FRACTURE
OPEN VS. CLOSED FRACTURE

- Open fracture shows communication of the fracture with the outside environment
- Simple puncture wound to massive open near amputation
- The bone can produce the opening or the opening can produce the fracture
Open vs. Closed Fracture

- Closed has no break in the skin that communicates with the fracture
Open vs. Closed Fracture

- Open wound ≠ Open fracture
- The key: do the fracture and the wound communicate with each other?
OPEN FRACTURES
GUSTILO CLASSIFICATION

- Describes the type of soft tissue injury not necessarily the type of fracture comminution
- Developed by a Twin Cities Orthopedist
- Fractures of humerus (S42), forearm (S52), femur (S72), lower leg (S82)
- Three types
GUSTILO CLASSIFICATION

Type I

- Wound <1 cm w/minimal soft tissue injury
- Wound bed clean
- Simple fracture w/minimal comminution
- If treated w/IM nail, average healing 21-28 wks.
- ICD-10 7th character B,E,H,M,Q
GUSTILO CLASSIFICATION

Type II

- Wound >1 cm w/moderate crush/soft tissue injury
- Wound bed moderately contaminated
- Generally involves a direct blow to the limb
- Fracture w/some comminution
- If treated w/IM nail, average healing 26-28 wks.
- ICD-10 7\textsuperscript{th} character B,E,H,M,Q
GUSTILO CLASSIFICATION

- Type III
  - Fracture w/associated vascular injury needing repair
  - Segmental fracture w/displacement
  - Fracture w/diaphyseal segmental loss
  - Farmyard injuries or highly contaminated wounds
  - High velocity GSW
  - Fractures caused by crushing force from fast moving vehicle
- Three levels
- ICD-10 7th character C,F,J,N,R
GUSTILO CLASSIFICATION

- **Type III A**
  - Wound >10 cm w/crushed tissue & contamination
  - Soft tissue coverage of bone generally possible
  - If treated w/IM nail average healing 30-35 wks.

- **III B**
  - Wound >10cm w/crushed tissue & contamination
  - Soft tissue inadequate requiring graft/flap
  - Requires serial debridement
  - Fracture management varies, often done in stages
    - Debridement, reduction, stabilization and ex fix followed by subsequent debridement/wound mgmt. to final internal fixation

- **III C**
  - Major vascular injury requiring repair of limb for salvage
  - Fractures classified using the Mangled Extremity Severity Score (MESS)
  - May result in amputation
GUSTILO OPEN FRACTURE

Type III C
October 1, 2016 Guideline Change

- Default to open Type I or II (B, E, H, M, Q) when type is not specified
TYPE OF TREATMENT

- Open with or without internal fixation
- Percutaneous
- Closed
  - without manipulation
  - with manipulation
  - with manipulation with or without traction
- All=Global Surgery
TYPE OF TREATMENT

OPEN

- Fracture is visualized
- Internal or external or no fixation
  - Sometimes both
  - Internal fixation can be placed percutaneously
- ≠ Open FRACTURE
TYPE OF TREATMENT
OPEN

- IM (intramedullary) rodding
  - Bone is opened remote from the fracture site
    - Rod is placed down the intramedullary canal
    - Often screw fixation is placed at the proximal and
distal ends to prevent movement of the rod
  - Fracture is visualized only by x-ray
  - If no CPT code descriptor for IM rodding should be coded as open
    - CPT Musculoskeletal System Chapter guidelines
If open fracture was debridement performed?

- Debridement of open fractures 11010-11012 NOT 11010-11044
  - Also for debridement of open dislocations
  - Includes exploration of the wound

- Debridement of open fractures can be repeated/staged
  - Continue to report with 11010-11012 until definitive management of the fracture performed
  - Attach 58 modifier
  - Once fracture has been treated and treatment is directed at management of the wound report wound debridement codes

- Can be reported multiple times on same claim if different fractures and/or different levels of debridement
  - Mod 59
Debridement is more than washing/irrigating with “copious amounts” of antibiotic solution.

Documentation is the key:
- The level of tissue debrided
- Debris or other “junk”
- Wound may or may not be closed

Described in CPT as extensive, intensive.
TYPE OF TREATMENT

OPEN

- An OPEN fracture can be treated CLOSED with or without reduction
Type of Treatment
Percutaneous Skeletal Fixation

- Treatment is neither open nor closed
- Fracture fragments are not visualized
- Device is inserted through the skin with a minimal incision
  - May be seen with open treatment
- Usually done with imaging (fluoro, C-arm)
  - Use of imaging during the procedure is included in the procedure
TYPE OF TREATMENT
CLOSED

- Three methods per CPT
  - All = global fracture care
  - Without manipulation
  - With manipulation
  - With manipulation with or without skeletal traction
**TYPE OF TREATMENT CLOSED**

- **Manipulative reduction**
  - In other words, did the physician push on the fracture to reposition the bone
  - Sometimes this is done when the cast is applied

- **Cast application with “molding”**

- **Wedging of cast**

- **Look for post-reduction/casting x-rays**
Type of Treatment

Closed

- Closed management or “Fracture Care”
- In other words, no reduction
Non-Manipulative Fracture Care
With a few exceptions, if it is broken and a treatment/procedure is performed bill for the global service of management of the fracture
FRACTURE CARE
The Rule of Three

Rule #1

- Confirmed fracture diagnosis
  - ≠ Possible, probable, maybe, appears to be
FRACTURE CARE

The Rule of Three

Rule #2

- Institution/continuation of treatment
  - NOT ALL FRACTURES WILL BE TREATED WITH A CAST
  - i.e. stabilization of the fracture
  - Orthoses such as CAM walkers, Sarmiento sleeve
  - Per CPT Assistant, placement of immobilization by ED does not trump ability to bill fracture management
Fracture Care
The Rule of Three

Rule #2

- Institution/continuation of treatment
  - Fractures such as the proximal humerus, scapula, radial head and neck and clavicle cannot be immobilized in a cast
  - Standard of care is treatment in a sling
FRACTURE CARE
The Rule of Three

Rule #3

➢ Planned follow up
**Fracture Care**

- If plan is for manipulative procedure at a future date, non-manipulative fracture management should not be billed.

- If treatment is instituted, with the possibility for a manipulative procedure at a future date, bill non-manipulative fracture management.
  - Determination of subsequent procedure is dependent upon maintenance of fx position w/o addl treatment.
    - Addl procedure will require -58modifier.
FR ACTURE CARE

Exceptions

No one’s rule

- Phalangeal fractures treated w/buddy taping
- Pelvis fracture (excluding acetabulum)
- Metatarsal fracture treated with a stiff soled shoe
Fracture Care Exception
Vertebral body fractures

CPT 22310
“Closed treatment of vertebral body fracture(s) w/o manipulation, requiring and including casting or bracing”
Vertebral body fractures

CPT 22310

Per the AMA CPT Assistant June 2006, Volume 16, Issue 6, page 16

“In order to report the casting or strapping codes, the procedure must be performed by a physician or by other personnel under the direct supervision of a physician. As direct supervision indicates, the physician MUST BE PRESENT DURING THE PROCEDURE when a nonphysician is performing the splint application”
Vertebral Body Fractures

CPT 22310

What does this mean?
If the orthotist applies a TLSO (back brace) without the presence of the physician, no fracture care can be billed.
In general, reimbursement is nearly equal for fracture management vs. E&M

- Initial cast application cannot be billed with fracture management, may be billed with E&M
- Subsequent casts may be billed for both
- Cast materials can be billed for both
- X-rays can be billed for both
- E&M cannot be billed for either situation if the primary reason for the visit is a cast change (-25 modifier criteria)
FRACTURE CARE VS. ITEMIZED?

The bottom line…….

THERE IS NO WRITTEN RULE

- The decision to bill fracture care vs. itemized is ultimately an internal business decision
- Suggest development of policies so that all coders/physicians are consistent
- CMS is reviewing global period
- CMS does not expect charges for itemized billing to far exceed that of global fx care
FRACTURE CARE VS. ITEMIZED?

If decision is to bill global fracture care, make sure patient is informed.
“If a cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture without manipulation CPT code may be reported.”
Non-Manipulative Fracture Care
2013 CCI

Written inquiry response February 8, 2013

“This policy is applicable to any combination of multiple bone fractures treated with the same cast, strapping or splinting and without manipulation. It is NOT limited to multiple fractures of the same type of bone (e.g. metacarpals, carpals). There is a single 90 day global period applicable to these multiple fractures which includes all the post-operative evaluation and management services related to the closed treatment of the fractures without manipulation.”
NON-MANIPULATIVE FRACTURE CARE

2013 CCI

Further response

- Includes non-manipulative management when any additional fracture may be treated with either closed or open reduction and all fractures will be treated with the same immobilization device.
14. If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment without manipulation CPT code may be reported. Additionally, if a single cast, strapping, or splint treats multiple fractures without manipulation in addition to one or more fracture(s) with manipulation, a closed fracture without manipulation CPT code should not be reported separately. These policies also apply to the closed treatment of multiple fractures not requiring application of a cast, strapping, or splint.

- If a cast, strapping, or splint applied after an open or percutaneous treatment of a fracture also treats a closed fracture without manipulation, a closed fracture without manipulation CPT code should not be reported separately.
“These principles also apply to the treatment of multiple dislocations or combinations of multiple closed fractures and dislocations. If multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported. Additionally, if a single cast, strapping, or splint treats any combination of closed dislocations and/or closed fractures without manipulation in addition to at least one closed dislocation or fracture that did require manipulation, only a single CPT code for closed treatment with manipulation of the dislocation or fracture may be reported.

Similarly, if multiple dislocations and/or fractures are treated with or without manipulation and do not require a cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment CPT code may be reported for the anatomic area that would have been treated by a single cast, strap or splint.”
“Finally, if a cast, strapping, or splint applied after an open or percutaneous treatment of a dislocation and/or fracture also treats a closed dislocation and/or fracture that did not require manipulation, a CPT code for closed dislocation or fracture treatment (without manipulation) should not be reported separately.”
Per AAOS, AMA and CMS the initial evaluation for treatment and diagnosis of the fracture is billable with a 57 modifier.

Just because treatment doesn’t involve slicing and dicing doesn’t mean the same thought process and risk management isn’t involved.

All fracture treatment codes currently carry a 90 day global period and are therefore considered a major procedure.
Fracture Care and the ER/UC

If ER/UC physician makes the diagnosis and applies a splint, the ER/UC physician should bill only for the E&M and splint application.

Why?
- No definitive treatment is being provided
- The ER/UC physician is not assuming care for management of the fracture and the results

This is supported by CMS and the AMA
FRACTURE CARE AND THE ER/UC

CPT introductory guidelines state:

“If a cast application or strapping is provided as an initial service in which no other procedure or treatment (eg. surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping and/or supply code in addition to an evaluation and management code as appropriate.”
Fracture Care and the ER/UC

NCCI Manual

“If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For OPPS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.”
Fracture Care and the ER/UC

- If ER/UC physician makes the diagnosis and performs a reduction, the ER/UC physician should bill the fracture management code with the 54 modifier unless the ER/UC physician provided a significant portion of the post operative care.
- Ortho would bill the fracture management code with 55 modifier or for some payors, E&M, subsequent casting codes.
  - There must be a written transfer of care from the ER (or other physician) and ortho must accept the transfer of care.
  - Claim must note the date the receiving physician assumed care (Box 19).
**SPLIT MANAGEMENT**

- Reimbursement with the 55 modifier equals the post operative portion of the fee schedule or approximately 20% of the allowable
- Receiving physician bills same CPT code w/55 mod
- Put date assumed/relinquished care in Box 19 (or ANSI equivalent)
- Exact # post-op days should be noted in Box 24G
- Cannot bill until after first encounter w/patient
**SPLIT MANAGEMENT**

- Split management should not be used when multiple physicians within the same group provide fracture management regardless of specialty if the physician reassigned benefits to the group.
  - MCM claims processing manual 100-04 Chapter 12 Section 40
Fracture management, regardless of type is considered a major “surgery” with a 90 day global period.

Application of the initial cast/splint (not orthosis) is ALWAYS included when billing any form of fracture management

- Application of an orthosis is not considered application of a cast/splint and should be billed with the appropriate L code only

Per CMS and AAOS, supplies are not included in the cast application or management of the fracture
Although by definition, cast applications fall outside of the global period, Medicare requires a 58 modifier on all subsequent cast applications during the global period.

Why? Cast application codes have a zero day global period.
Effective July 1, 2001, A4570, A4580 and A4590 are no longer valid HCPCS codes under Medicare for cast materials related to fractures

- 51 Q codes were established for cast supplies
- Some healthplans still use A codes or 99070
Cast/Splint Application

Q Codes

- Each Q code includes all of the materials needed for application of the cast with the exception of waterproof cast padding (Gortex/Procel, Delta lite)
  - You should not be billing for multiple units/multiple rolls of material, padding, stockinette, etc.
Casting/Splint Application Q Codes

- Type of cast applied
  - Short arm, long arm, short leg, etc.
- Type of cast material
  - Fiberglass/synthetic or plaster
- The age of the patient
  - Pediatric = age 10 and under
CAST SUPPLIES Q CODES

- Q4006 long arm cast, adult fiberglass
- Q4008 long arm cast, pediatric, fiberglass
- Q4010 short arm cast, adult, fiberglass
- Q4012 short arm cast, pediatric, fiberglass
- Q4030 long leg cast, adult, fiberglass
- Q4032 long leg cast, pediatric, fiberglass
- Q4038 short leg cast, adult, fiberglass
- Q4040 short leg cast, pediatric fiberglass

*Not all inclusive
CAST SUPPLIES
GORTEX/PROCCEL

- Q4050
- Description of supply must be on claim
  - “waterproof cast padding short arm cast”
- Some healthplans will want an invoice
- Some Medicare carriers cover only if documentation of medical necessity; others do not cover and consider provider responsibility (NGS and WPS)
- Some healthplans do not cover and require ABN to bill patient
STRESS/PATHOLOGIC FRACTURES

- As long as the documentation supports fracture management treatment billing can be considered fracture management.
DISLOCATIONS, SPRAINS AND STRAINS

- A dislocation is never treated without a procedure being performed.
- There is no CPT code for medical management of a sprain/strain.
  - E&M and cast application if performed.
  - 25 modifier criteria must be met.
FRACTURE-DISLOCATION

- If both a fracture and dislocation of the same anatomic site and if both are treated, bill only treatment of the fracture unless there is a combination code (eg. Monteggia, Galeazzi)
- If initial treatment is reduction of the dislocation then separate session for reduction of the fracture, bill the appropriate dislocation reduction code followed by the appropriate fracture reduction code with a 58 modifier
UNSUCCESSFUL CLOSED REDUCTION

- Closed converted to open reduction at same patient encounter only the more extensive open procedure can be billed
MALUNION-NONUNION

- When available CPT selection should be for repair nonunion/malunion not osteotomy.
- If no malunion/nonunion CPT code available, may use fracture treatment code for nonunion repair and generally osteotomy code for malunion repair.
Fracture-dislocation-per AHA Coding Clinic Quarter 3 1990 when documented as fracture-dislocation only the fracture ICD-9 should be assigned
DIAGNOSES

- Multiple fractures should use multiple diagnosis codes in order of severity of injury
ICD-10 AND FRACTURES

- Specificity for right and left
- Non-union, malunion, delayed union now attached to a specific fracture
- Specificity for displaced vs. nondisplaced
  - If not defined default to displaced
- 7th digit specificity for initial and subsequent encounters, healing vs. delayed vs. nonunion vs. malunion
  - Follows for traumatic, stress and pathologic fractures
- Late effect replaced by 7th digit sequelae
- Initial fracture category carried throughout course of treatment
ICD-10 AND FRACTURES

- Extensive expansion of fracture classifications
  - Spiral
  - Segmental vs. nonsegmental
  - 2 part vs. 3 part vs. 4 part
  - Etc. etc. etc.

- Stress fractures expanded for bone

- Pathologic fractures expanded for underlying cause
  - Neoplasms, osteoporosis

- Open fracture classifications based upon Gustilo classification system; carried throughout treatment

- Salter-Harris classification
ICD-10 AND FRACTURES

- Dislocations
  - No open dislocation
  - Code also open wound
ICD-10 CM GUIDELINES

Sequencing = order

- Most serious as determined by provider and the injury that is the focus of treatment based upon documentation first listed
- Superficial injuries such as abrasions or contusions should not be coded with a more severe injury of the same site
- Primary injury with minor damage to nerves and/or blood vessels, primary injury sequenced first followed by injuries to nerves/blood vessels
- When primary injury is to a blood vessel or nerve(s) that injury is sequenced first
CHAPTER 19 CATEGORY BLOCKS

- S00-S09 Head
- S10-S19 Neck
- S20-29 Thorax
- S30-39 Abdomen, lower back, lumbar spine, pelvis, external genitalia
- S40-49 Shoulder and upper arm
- S50-59 Elbow and forearm
- S60-69 Wrist, hand and fingers
- S70-79 Hip and thigh
- S80-89 Knee and lower leg
- S90-99 Ankle and foot
**Code Structure**

Code structure ex. S72.361A

1st character chapter category S-injury
2nd character-body area
3rd character-injury type
4th character-anatomic site
5th character-severity
6th character-laterality/location

**Category**

**Etiology, Anatomic site, Severity/Laterality**

**Stage**
**Code Structure 3rd Character**

- 0 = superficial injuries
- 1 = open wounds
- 2 = fracture
- 3 = subluxation/dislocation
- 4 = nerve
- 5 = blood vessel
- 6 = muscle, tendon, fascia
- 7 = crush injury
- 8 = amputation
- 9 = other, epiphyseal fractures and unspecified
CODE STRUCTURE 4\textsuperscript{TH} AND 5\textsuperscript{TH} CHARACTER

- Fracture
  - Open, closed
  - Displaced, nondisplaced
  - Configuration
  - Location
  - Type
  - Laterality
Code Structure 4th and 5th Character

- Subluxation/dislocation/sprain
  - Joint
  - Laterality
  - Position of dislocation (anterior, posterior, inferior, lateral)
  - % of dislocation
A = initial encounter

- Patient is receiving “active” treatment
- Initial visit (ER or evaluation and continuing treatment by same or different physician)
- Surgery
- Fracture specific
  - Initial visit if delayed seeking treatment
    - Includes if result of visit is malunion/nonunion/delayed union
  - A initial encounter for closed fracture
  - B initial encounter for open fracture type I or II or open fracture NOS
  - C initial encounter for open fracture type IIIA, IIIB or IIIC
7TH CHARACTER EXTENDER

A = initial encounter

- Key is not whether the provider seeing the patient is new or different, but whether that provider will be providing active treatment and plans to continue to treat
7TH CHARACTER EXTENDER

D= Subsequent encounter

- Completed “active” treatment and is now receiving routine follow up care for the condition during healing or recovery phase
- Cast change or removal, removal of internal or external fixation, medication adjustment, x-rays, other aftercare and follow up after treatment following treatment of the injury
- =V aftercare and follow up codes in ICD-9
Mrs. Jones presents today for evaluation of her left wrist following a fall earlier today. She notes pain, swelling and tenderness with increased pain with motion of the fingers. Radiographs reveal a non-displaced extraarticular fracture of the distal radius. I am concern as to the stability of this fracture however since it is currently in alignment we will attempt to treat this conservatively. She will be placed in a well-padded, well-molded short arm cast and return next week for reevaluation.

S52.552A Other extraarticular fracture of lower end of left radius initial encounter for closed fracture
Mrs. Jones returns today for reevaluation of her nondisplaced extraarticular fracture of the left distal radius. X-rays taken today show maintenance of alignment. Cast remains stable. We will have her return again next week. If the position remains satisfactory we will continue with non-manipulative management and follow-up in a couple of weeks.

S52.552D Other extraarticular fracture of lower end of left radius subsequent encounter for closed fracture
EXAMPLE

Mrs. Jones returns today for reevaluation of her left wrist three weeks following a fall. X-rays taken today show the fracture has shifted. Although not intraarticular, joint position is no longer satisfactory. We will take her to the OR later today for closed possible open reduction.

Office encounter:
S52.552D Other extraarticular fracture of lower end of left radius subsequent encounter for closed fracture

Surgery:
S52.552A Other extraarticular fracture of lower end of left radius initial encounter for closed fracture
Subsequent encounter fracture specific

- **Routine healing**
  - D subsequent encounter for closed fracture with routine healing
  - E subsequent encounter for open fracture type I or II with routine healing
  - F subsequent encounter for open fracture type IIIA, IIIB or IIIC with routine healing

- **Delayed healing**
  - G subsequent encounter for closed fracture with delayed healing
  - H subsequent encounter for open fracture type I or II with delayed healing
  - J subsequent encounter for open fracture type IIIA, IIIB or IIIC with delayed healing
Subsequent encounter fracture specific

- Subsequent encounter with complications *Nonunion*
  - K subsequent encounter for closed fracture with nonunion
  - M subsequent encounter for open fracture type I or II with nonunion
  - N subsequent encounter for open fracture type IIIA, IIIB or IIIC with nonunion

- Subsequent encounter with complications *Malunion*
  - P subsequent encounter for closed fracture with malunion
  - Q subsequent encounter for open fracture type I or II with malunion
  - R subsequent encounter for open fracture type IIIA, IIIB or IIIC with malunion
7\textsuperscript{TH} \textbf{CHARACTER EXTENDER} \\
\textbf{DELAYED/NONUNION/MALUNION}

- First time seen by provider without any prior treatment 7\textsuperscript{th} character A
- Surgery after seen appropriate 7\textsuperscript{th} character for complication
- Remains during course
Jesse is a 25 year old who injured his right wrist approximately a month ago. He noted discomfort with motion and grasp but did not notice any appreciable swelling or deformity so thought it was just sprained. He presents today due to continued discomfort. Evaluation shows tenderness in the snuff box and pain with grasp. Radiographs reveal a nonunion fracture of the waist of the scaphoid. Position is satisfactory however due to his activity level as well as the location of the fracture he would be best served with surgical intervention. He is placed into a well padded thumb spica. We will get him on to the schedule for ORIF.

S62.024A Nondisplaced fracture of middle third of navicular [scaphoid]bone of right wrist initial encounter for closed fracture
Jesse is a 25 year old who injured his right wrist approximately a month ago. At that time he was evaluated and noted to have a nondisplaced fracture of the waist of the scaphoid. He was placed into a thumb spica cast and returns today for reevaluation and radiographs. Radiographs obtained today reveal a delayed union. He is a high level goalie with Lancers. In order to get him back as quickly as possible we will treat this with ORIF and bone grafting.

S62.024G Nondisplaced fracture of middle third of navicular [scaphoid]bone of right wrist subsequent encounter for delayed healing
7th Character Extender

- **S**-Sequela i.e. Late Effects
  - Complications or conditions that develop as a direct result of an injury
  - Code both the injury code that caused the sequela and the sequela itself
    - Specific type of sequela should be coded first.
    - Same concept as in ICD-9 using late effect codes
    - S appended to injury code only
7TH CHARACTER EXTENDER

• Remember, 7th character extender must always be the 7th character. Codes that are not 6 characters long will require the “X” placeholder. More than one placeholder may be needed.
OCTOBER 2016 CHANGES

- M84.75- Atypical femoral fracture
  - Complete/incomplete
    - Complete transverse or oblique
  - Laterality
  - 7\textsuperscript{th} character
  - Subtrochanteric/diaphyseal
  - Patients treated with bisphosphonates

- Periprosthetic fracture moved to M97.- from T codes
  - Expanded body area
October 2016 Changes

- S92.81- Other fracture of foot (sesamoid)
- S99.0- Physeal/Salter-Harris fracture calcaneus
- S99.1- Physeal/Salter-Harris fracture metatarsal
- S99.2- Physeal/Salter-Harris fracture phalanx “toe”
  - Laterality
  - 7th character
Thank You

rubywdwrd@gmail.com
952 210-4847