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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Stand for a Breakdown in Your Fracture Care Coding

Follow these 3 tips for frustration-free care claims.

If carriers are finding fault with your fracture care claims, you can break the pattern by mastering fracture ICD-9 coding and knowing how to distinguish between open and closed fractures. Use these three expert tips to make your fracture care coding a snap.

1. Keep an eye on ICD-9 fourth and fifth digits.

Incorrect diagnosis coding is one of the primary reasons for claim denial in fracture care, says **Elisabeth P. Fulton, CPC,** coding and auditing department supervisor at **Orthopedic Specialists of the Carolinas** in Winston-Salem, NC. When coding fractures, you need to be as specific as you can with your diagnosis codes, she adds.

Fracture codes extend to the fourth or fifth digit, depending on the diagnosis. The fourth digit indicates if the fracture is open or closed, while the fifth digit indicates the specific location of the fracture. For example, you would report 812.21 (Fracture of humerus; closed; shaft of humerus) for a patient with a closed fracture in the shaft of his humerus. The fourth digit "2" indicates "shaft or unspecified part, closed" and the fifth digit "1" shows the more specific location "shaft of humerus."

Scenario: A 25-year-old male sustains a broken metacarpal in his right hand, a fractured mandible, and a fractured left femur during a highway motorcycle accident. The patient receives closed fracture treatment for each fracture.

You code: Make sure to match the ICD-9 code for each fracture with the appropriate fracture care code, says Fulton. And when you code multiple fractures at one time, report the fracture care code with the highest RVU (relative value unit) first, advises Fulton. You want the highest dollar value to go first on your claim because the multiple surgery rules will apply: The carrier will pay the first procedure at 100 percent, and the second and subsequent procedures at 50 percent of their allowance, says **Michelle Logsdon, CPC, CCS-P, CMC**, of **Cash Flow Inc.** in Brick, NJ.

For the above scenario, you might report the following diagnosis and CPT codes:

1. 821.01 (Fracture of other and unspecified parts of femur; shaft or unspecified part, closed; shaft) linked to 27502 (Closed treatment of femoral shaft fracture with manipulation, with or without skin or skeletal traction) for the fractured femur treatment. The 2005 physician fee schedule lists 10.56 RVUs for 27502, making this your primary fracture care code. You should list this code first on your claim.
2. 802.20 (Fracture of face bones; mandible, closed; unspecified site) linked to 21450 (Closed treatment of mandibular fracture; without manipulation) for treatment of the fractured mandible. Code 21450 has 2.97 RVUs, so you would list it second.
3. 815.03 (Fracture of metacarpal bone[s]; closed; shaft of metacarpal bone[s]) linked to 26600 (Closed treatment of a metacarpal fracture, single; without manipulation, each bone) for treating the broken metacarpal. Code 26600 has 1.96 RVUs, meaning you would report this code last.

2. Be Aware of V Codes

Although many offices and carriers tend to ignore V codes, they can be useful for follow-up fracture care visits because they paint a clearer picture for the carrier of the patient's complicated condition, explains Fulton.

The ICD-9-CM manual lists fracture aftercare codes that you should report for subsequent visits after the patient's initial fracture care, says **Margie Vaught, CPC, CCS-P, MCS-P**, a coding consultant in Ellensburg, WA.

According to the ICD-9 Coding Clinic, Vol. 19, No. 4, when coding follow-up visits, you should report code V54.1x (Aftercare for healing traumatic fracture) for a fracture that results from a trauma - such as rolling an ankle or hitting a toe - and use V54.2x (Aftercare for healing pathologic fracture) for a fracture caused by conditions such as a bone lesion or arthritis.

Do not report V58.43 (Other aftercare following surgery; aftercare following surgery for injury and trauma) unless a patient is receiving treatment for a healing traumatic fracture (V54.1x) and for other injuries as well.

3. Open Your Eyes to Open Fracture, Closed Treatment

Coders often have problems determining if a fracture repair is open or closed, Fulton says. They need to understand an open fracture does not necessarily require open treatment to repair, says Fulton.

"Coders think that because it's an open fracture, they should bill it open reduction, internal fixation, and that's just not always the case," Fulton says, because physicians can often treat an open fracture with a closed treatment. For example, a physician may be able to push a bone back through the skin and align it properly without having to open the skin.

A physician cannot perform open fracture treatment in an office - this treatment must be done in surgery, Logsdon points out. If a physician's documentation is unclear as to open or closed treatment, code the fracture care as closed if the provider performed the treatment in an office setting. For instance, if the physician notes that he performed in-office fracture care on an open fracture of the humerus, you would report the appropriate closed fracture care code because he must have performed closed treatment if he rendered the service in the office.