Fracture Care

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Q. Will you please help me understand initial visit, subsequent visit, and sequelae related to fracture care? If the patient is treated elsewhere for a fracture and the provider just stabilizes the fracture and instructs the patient to then come to my office for reduction, is this a subsequent visit or an initial visit?

A. *International Classification of Diseases 10th Revision, Clinical Modification* (ICD-10-CM) guidelines state that a seventh character, **A**, is used for the initial encounter for the injury or condition while the patient is receiving active treatment for the injury. Examples of active treatment are

- Surgical treatment
- Emergency department (ED) encounter
- Evaluation and treatment by a new physician

Evaluation and treatment by a new physician is sometimes misunderstood by health-care providers and coders alike. You must determine whether the patient has previously received active treatment for this condition in any setting or by any provider.

For example, the patient is evaluated in an ED for a closed fracture of the distal phalanx of the right index finger. The ED provides comfort care by icing and immobilizing the finger, and then instructs the patient to follow up with an urgent care center in the morning. The ED's billing department reports ICD-10-CM code **S62.630A** because this is the patient's initial visit.

When the urgent care center rechecks the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. The *Current Procedural Terminology* (CPT) code to bill is **26755**, "closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each." Per the ICD-10-CM guidelines, you would again report ICD-10-CM code **S62.630A** because this is the first time the patient is receiving active treatment from the urgent care center.

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Subsequent care is defined in the ICD-10-CM guidelines as "encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase," and it is assigned using the injury code with the seventh character **D**, "subsequent encounter for fracture with routine healing." Examples of subsequent care are

- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other aftercare
- Follow-up visits after injury treatment

In the example of the patient with the phalanx fracture, if the fracture is healing as it should at the subsequent visit to the urgent care center, the center's office would report **S62.630D**, "displaced fracture of distal phalanx of right index finger, subsequent encounter with routine healing." CPT code **99024**, "postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for . . . reason(s) related to the original procedure," could also be included on the claim at no cost to represent the evaluation and management (E/M) portion of the visit.

Sequelae are the late effects of an injury and thus are assigned using the injury code with the seventh character **S**, "for use for complications or conditions that arise as a direct result of an injury, such as a scar formation after a burn. The scars are sequelae of the burn," according to ICD-10-CM guidelines.

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For example, a patient sustained a fractured right ankle that is now healed. However, the patient is in pain and sometimes has a limp as a result of the injury. When the patient presents for treatment for the pain, you would assign ICD-10-CM codes **G89.21**, "chronic pain due to trauma," and **S82.891S**, "other fractures of lower right leg." ■

Q. What services can we bill for when we provide definitive care for a fracture?

A. If you perform a service for definitive care of a fracture and plan to follow the patient through the healing process, you will bill the appropriate CPT code for the treatment performed, as well as CPT codes for any of the following:

- X-rays
- Cast supplies
- Splint supplies and/or durable medical equipment devices
- All supplies provided (e.g., sling, walking boot)

Refer to CPT codes in code range of **70000** through **79999** for the x-rays, and Healthcare Common Procedure Coding System Level II codes for the supplies.

If a separate E/M service was provided and documented separately during the initial visit, you would bill the appropriate E/M code (**99201**through **99215**) with modifier **-57**, which is described as follows: "decision for surgery: an evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service." You would not bill for the application of the splint or cast, because that is included in the CPT code for definitive treatment.

All postoperative visits for the fracture are included in the definitive care code for 90 days following the initial treatment. ■