BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Fracture Care

Active

Section: Surgery/Interventional
Policy Number: 006
Effective Date: 03/01/24

Description

This policy addresses Blue Cross and Blue Shield of Minnesota's (Blue Cross) requirements for the coding and reimbursement of fracture care.

Definitions

Per Current Procedural Terminology (CPT®), fracture/dislocation treatment codes are structured by type of treatment (closed, open, percutaneous) and the type of stabilization (fixation, immobilization). There is no coding correlation between the type of fracture or dislocation and the type of treatment provided. For example, a closed fracture may require open treatment.

Refer to the Surgery/Musculoskeletal System subsection guidelines in CPT for detailed fracture/dislocation treatment definitions.

Policy Statement

Correct coding and reimbursement for fracture care is dependent upon a number of factors including whether or not:

- the initial cast, splint or strapping is performed at the same time as a restorative procedure (i.e., surgical repair, closed or open reduction)
- the same or a different physician will be assuming responsibility for follow up care
- the casting, splinting, or strapping is the initial or a replacement application

Initial Cast, Splint, or Strapping Without Restorative Procedure
Casting, splinting, or strapping may be performed without an associated musculoskeletal-restorative treatment; In some cases, restorative treatment may not necessary (e.g., strapping performed for pain relief only), or the restorative treatment will be performed at a later date, typically by an orthopedist. For example, an emergency department (ED) physician may apply a splint to stabilize a fracture and then instruct the patient to follow up with an orthopedic surgeon for further care. In this case, the ED physician should report the splint application, and if the key components for an evaluation and management (E/M) code are met, an E/M with modifier 25. Blue Cross will consider both for reimbursement.

Note: If a restorative treatment is subsequently performed by the orthopedic surgeon, the application of the splint by the ED physician is not considered to be preoperative care.Therefore, the use of modifier 56 (Preoperative management only) by the ED physician would not be appropriate and will not be reimbursed.

Initial Cast, Splint, or Strapping with Restorative Procedure
According to CPT, “All services that appear in the Musculoskeletal System section include the application and removal of the first cast, splint or traction device when performed.” Therefore, when a physician or other qualified health care professional performs a restorative procedure such as fracture reduction or stabilization, reimbursement for the initial cast, splint, or strapping application and/or removal is considered to be included in the payment for the restorative procedure when performed by the same entity (physician/ qualified health care professional or group practice.) Blue Cross will not separately reimburse for the cast, splint or strapping application or removal.

Global and Split Fracture Care
The physician who performs the restorative procedure, typically an orthopedic surgeon, should bill globally using the appropriate procedure code with no modifier. The physician may also bill for an E/M service on the day before, or the day of the surgical procedure if the key components of the E/M are met and modifier 57 (decision for surgery) is appended to the E/M code.

The performing physician is responsible for all subsequent fracture care under the global surgical package. The follow up fracture care is, therefore, not separately reimbursable. Refer to *Commercial Surgery/Interventional Procedure - 007 Global Surgical Package Reimbursement Policy*.

Splitting fracture care between an ED physician and another physician, such as the orthopedic surgeon may be necessary when restorative treatment is performed in the Emergency Department. Refer to *Commercial Surgery/Interventional Procedure – 024 Split Surgical Package Reimbursement Policy.*

Restorative Procedure in the Emergency Department
If the ED physician performs restorative treatment such as a closed reduction with the application of a splint or cast, and then refers the patient to an orthopedic surgeon, the ED physician should report the fracture treatment code with modifier 54 (Surgical Care Only).

A non-ED physician, such as the orthopedic surgeon, who then provides casting, follow-up evaluation(s) and management of the fracture until healed, may submit a claim for the fracture treatment code with CPT modifier 55 (follow-up care only).

Repeat Reduction
If satisfactory alignment (reduction) of a fracture or dislocation is not maintained and requires subsequent re-reduction by the same physician, modifier 76 should be appended to the fracture/dislocation treatment code.

Removal or Replacement of Cast, Splint or Strapping
As stated above, removal of the first cast, splint or traction device is included in the restorative procedure and is therefore not separately reimbursable, unless the initial application of the cast, splint or strapping was performed by a different entity.

Subsequent replacement of cast, splint or strapping during or after the global period may be reported separately and will be considered for reimbursement. Replacement may be necessary,

for example, if the patient gets the original splint wet, and it must be replaced. In this case the replacement splint is separately reimbursable.

Supplies
No additional reimbursement will be made for surgical trays, surgical or other miscellaneous supply codes A4550, A4649, and 99070. The allowance for these codes is considered bundled into payment for the other services rendered.

If the cast, splint, or strapping is applied in the office, supplies may be billed separately with the appropriate HCPCS codes (Q4001-Q4051). Cast, splint, and strapping supplies provided in a facility place of service are not reimbursable as they are considered to be included in the facility's reimbursement for services provided.

Other supplies used in the office place of service are generally considered incidental or bundled into payment for any other service performed.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	25	54	55	56	57	76
ICD-10 Diagnosis:	N/A					
ICD-10 Procedure:	N/A					

CPT/HCPCS: Refer to Appendix
Revenue Codes N/A

Resources

CPT® Assistant, January 2018
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Medicare Claims Processing Manual. Chapter 12 –Section 40.1

Policy History

05/19/2015	Initial Committee Approval
06/09/2016	Annual Policy Review
05/01/2018	Annual Policy Review
07/06/2020	Annual Policy Review
06/27/2023	Annual Policy Review
02/27/2024	Annual Policy Review

BlueCross BlueShield Minnesota

Appendix

29000	29010	29015	29035	29040	29044	29046	29049	29055	29058
29065	29075	29085	29086	29105	29125	29126	29130	29131	29200
29240	29260	29280	29305	29325	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520	29530	29540
29550	29580	29581	29584	29700	29705	29710	29720	29730	29740
29750	29799								
A4550	A4565	A4570	A4580	A4590	A4649				
Q4001	Q4002	Q4003	Q4004	Q4005	Q4006	Q4007	Q4008	Q4009	Q4010
Q4011	Q4012	Q4013	Q4014	Q4015	Q4016	Q4017	Q4018	Q4019	Q4020
Q4021	Q4022	Q4023	Q4024	Q4025	Q4026	Q4027	Q4028	Q4029	Q4030
Q4031	Q4032	Q4033	Q4034	Q4035	Q4036	Q4037	Q4038	Q4039	Q4040
Q4041	Q4042	Q4043	Q4044	Q4045	Q4046	Q4047	Q4048	Q4049	Q4050
Q4051									
S8450	S8451	S8452							