KAISER PERMANENTE®

PAYMENT POLICY

FRACTURE CARE IN EMERGENCY DEPARTMENT WITHOUT MANIPULATION

Scope

This policy applies to:

☒ Kaiser Permanente Health Plan of Washington

☒ Kaiser Permanente Health Plan of Washington Options, Inc.

☒ Commercial

☒ Medicare

☐ Medicaid

Policy

Original Effective Date: July 1, 2022

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) will not reimburse fracture care billed without a manipulation procedure code when billed on a professional claim by a physician in the emergency department (ED) setting.

Billing/Coding Guidelines

All claims must be billed according to Centers for Medicare & Medicaid Services guidelines.

Including but not limited to the following CPT Codes:

CPT Code	Description
25600	Closed treatment of distal radial fracture or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation
27786	Closed treatment of distal fibular fracture; without manipulation
23600	Closed treatment of proximal humeral fracture; without manipulation
26720	Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each
26600	Closed treatment of metacarpal fracture, single; without manipulation, each bone
23500	Closed treatment of clavicular fracture; without manipulation
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each

27520	Closed treatment of patellar fracture; without manipulation
24650	Closed treatment of radial head or neck fracture; without manipulation
27760	Closed treatment of medial malleolus fracture; without manipulation

Policy Definitions

Not Applicable

Prerequisite(s)

CMS, CPT®, the American Academy of Orthopaedic Surgeons (AAOS), and the American College of Emergency Physicians (ACEP) agree that an emergency department (ED) physician should not report a global fracture care code unless two situations occur:

- The ED physician is performing a “restorative” treatment, which has been interpreted to infer performing a reduction/manipulation of the fracture — not simply applying a splint/cast/brace; or
- The ED physician will be providing the global package to this patient, meaning he or she will provide follow up during the post-op period.

If these two situations are not present, the ED physician should only report the appropriate evaluation and management (E/M) CPT® code, and possibly the application of a cast/splint, if performed. No official source specifies the length of time between the ED visit and the follow-up care as a determining value for reporting a global code.

References

Billing for Fracture Care: Emergency Department vs. Physician/Orthopedic Office – Medicare Celerian Group Company (CGS)

Set the Record Straight when Reporting Global Fracture Care – American Academy of Professional Coders (AAPC)

Fracture Codes, Strapping and Splint application codes S9088 code – Journal of Urgent Care Medicine (JUCM)

Frequently Asked Questions

Not Applicable

Revision History

01/19/2022 – New Policy

Note: This information is intended to serve only as a general reference resource regarding reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, we may use reasonable discretion in interpreting and applying this policy to services being delivered in a particular case. Further, the policy does not cover all issues related to reimbursement for services rendered to our enrollees as legislative mandates, the provider contracts, the enrollee's benefit coverage documents, and the Provider Manual all may supplement or in some cases supersede this policy. This policy may be modified from time to time by publishing a new version of the policy on Kaiser Permanente provider website; however, the information presented in this policy is believed to be accurate and current as of the date of publication.