ICD-10 Radiology Guidance: ***FRACTURES***

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ICD-10 ESSENTIALS for FRACTURES

The following elements are essential for the proper ICD-10-CM coding of **Fractures**:

TRAUMATIC or PATHOLOGICAL

- All fractures must be specified as to type of fracture
- There is no default, although type can sometimes be inferred

LOCATION / LATERALITY

- **Name** of the bone
- **Specific location** of the fracture on the bone
- **Left** or **Right** side of the body

FRACTURE TYPE / PATTERN

- e.g., Transverse, Oblique, Greenstick
- Default is *Unspecified*

DISPLACED or NON-DISPLACED

- Default is *Displaced*

OPEN or CLOSED

- Default is *Closed*

EPISODE OF CARE

- Initial, Subsequent or Sequela
- There is no default (coders will infer if possible)

HEALING PROCESS

- Routine, Delayed, Malunion or Non-Union
- There is no default (coders will infer Routine if possible)

CLASSIFICATION

- Only used with certain type of open fractures and locations
- e.g., Gustilo, Salter-Harris, Neer classifications
- There is a default if not stated

The magnitude of change for Fractures with ICD-10-CM is significant.

The number of fracture codes increases from 747 ICD-9 codes to **17,099 ICD-10 codes**. When possible, **all essential elements** outlined above should be documented in the patient record.

Traumatic vs. Pathological Fractures

ICD-10 requires all fractures to be documented as traumatic or pathologic.

- There is not a "default" or "unspecified" option in ICD-10.
- The coder will use the provided documentation to make a reasonable determination if the fracture is traumatic or pathological. If that determination can't be made from the documentation, the report will be returned for additional information.

For the purposes of coding, "compression fracture" does not equate to pathological fracture.

- If stated as compression fracture, the documentation must specify if the fracture was due to trauma or disease process.

If the fracture was caused by disease process, the disease process should be specified, if known.

- Pathological fractures are specified as:
  - In Neoplastic disease
  - In Osteoporosis
  - In Other disease
  - Not elsewhere classified

ICD-10 guidelines state that a fracture should be reported as *pathological* if a patient with known osteoporosis suffers a fracture from a minor fall that would not usually break a healthy bone.

Location

The specific bone and specific location of the fracture on the bone should be documented (e.g. mid-cervical fracture of left femur, fracture of anterior process of left calcaneus, etc.). Providing this information in the documentation will allow the case to be reported using the highest level of specificity. There is an unspecified option if the specific location is not documented.

Laterality

ICD-10 differs from ICD-9 in that it allows for the coding of laterality including right, left and bilateral. Laterality can be obtained either from the indication or from the procedure description. There is an unspecified option if the laterality is not known.

Type of Fracture

Type of fracture is a new concept in ICD-10 and the specific type of fracture should be documented (e.g., transverse, greenstick, spiral, etc.) When a long bone fracture is diagnosed, ICD-10 provides specific choices for the type of fracture. Providing this information in the documentation will allow the case to be reported using the highest level of specificity. There is an unspecified option if the type of fracture is not documented.

Displaced or Non-displaced Fractures

ICD-10 states that if the fracture is not documented as displaced or non-displaced, the fracture should be coded as displaced (default). If a fracture is non-displaced, it must be documented.

Closed or Open Fractures

ICD-10 states that if a fracture is not documented as closed or open, the fracture should be coded as closed (default). If a fracture is open, it must be documented.

Episode of Care

A significant change in ICD-10 is the need to assign a code based on the Episode of Care**.**

- There is not a "default" or "unspecified" option for episode of care.
- The coder will use the provided documentation to make a reasonable determination of the episode of care. If that determination can't be made from the documentation, the report will be returned for additional information.

There are 3 general options for Episode of Care:

- Initial encounter
  - When the patient is receiving active treatment for the injury, poisoning, or other consequences of an external cause.
  - Examples:
    - ED encounters (even if the injury occurred earlier)
    - Surgical treatment
    - Evaluation and treatment by a new physician
    - Delay in seeking treatment for a fracture or nonunion (fell 2 days ago with persistent pain in arm-fracture coded as initial)
    - Exam performed following ORIF or other surgical repair

- Subsequent Encounter
  - After active treatment and the patient is receiving routine care during the healing or recovery phase
  - Examples:
    - Cast change or removal, removal of internal or external fixation device
    - Medication adjustment
    - Other aftercare and follow-up visits following treatment of the condition
- Sequela
  - Complications or conditions that arise as a direct result of a condition
  - Examples from traumatic injuries include:
    - Scars resulting from a burn
    - Deformity
    - Post-traumatic arthritis
    - Avascular necrosis

Healing Process

When a patient is seen for a subsequent encounter (i.e., follow-up) for a fracture the healing process must be documented:

- Routine healing
- Delayed healing
- Nonunion
- Malunion

There is not a "default" or "unspecified" option for the type of healing. Coders will infer routine healing where possible.

Classification

Additional options are available to further specify open fractures of the shafts of long bones using the Gustilo-Anderson Fracture Classification system including:

- Type I
- Type II
- Type IIIa
- Type IIIb
- Type IIIc

The classification should be documented when known. The options containing "Type I and II" are identified as default in ICD-10.

Sources:

ICD-10-CM Draft Official Guidelines for Coding and Reporting 2014; Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), 2013.

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"Take the Fear Out of ICD-10-CM Fracture Coding," HC Pro/Just Coding, Jan 24, 2012.

"ICD-10 for Radiology: Trauma and External Causes," Coding Strategies Inc., October 2013.

"Ferocious Fracture Documentation for ICD-10," Maley, Margaret, November, 2013; http://www.aaos.org/news/aaosnow/nov13/managing7.asp.