Communication with the Physician Managing Ongoing Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

Coding Specifications

Codes required to document patient has fracture of the hip, spine or distal radius and a visit or procedure occurred:

An ICD-9-CM diagnosis code for fracture of the hip, spine or distal radius and a CPT code for a visit OR a diagnosis of fracture of the hip, spine or distal radius and a CPT procedure code are required to identify patients to be included in this measure.

Note: This measure should be reported at one of the following two instances if communication post fracture has occurred or is planned within 3 months of fracture.

1) *During an office visit with ICD-9-CM diagnosis code for fracture of hip, spine or distal radius OR*
2) *At the time of a procedure to repair a fracture*

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Option 1

Fracture of the hip, spine or distal radius ICD-9-CM diagnosis codes

- 733.00, 733.01, 733.02, 733.03, 733.09 (osteoporosis)
- 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08 (cervical fracture)
- 805.2 (dorsal — thoracic fracture)
- 805.4 (lumbar fracture)
- 805.6, 805.8 (sacrum and coccyx fracture)
- 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54 (radius and ulna fracture)
- 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8 (femur fracture)

AND

CPT codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

OR

Option 2

Fracture of the hip, spine or distal radius ICD-9-CM diagnosis codes

- 733.00, 733.01, 733.02, 733.03, 733.09 (osteoporosis)
- 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08 (cervical fracture)
- 805.2 (dorsal — thoracic fracture)
- 805.4 (lumbar fracture)
- 805.6, 805.8 (sacrum and coccyx fracture)
- 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54 (radius and ulna fracture)
- 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8 (femur fracture)

AND

CPT procedure codes

- 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524
- 25600, 25605, 25606, 25607, 25608, 25609
- 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***CPT II 5015F:*** Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- ***CPT II 5015F–1P:*** Documentation of medical reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis (eg, not indicated, contraindicated, other medical reason)
- ***CPT II 5015F–2P:*** Documentation of patient reason(s) for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis [with physician managing ongoing care of patient] (eg, patient declined, economic, social, religious, other patient reasons)
- ***CPT II 5015F–8P:*** No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

Communication with the Physician Managing Ongoing Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

Physician Quality Reporting System 2011 Measure 24, Effective Date 01/01/2011