

Information Regarding Fracture Care and Billing

Your insurance company requires that we report our services to them using a coding system known as CPT (Current Procedural Terminology). The CPT codes used to describe the services we did for you are found in the “surgery” section of the CPT workbook. This does not mean we are implying that you had an operation. This is merely the way the CPT book is organized for ease of use by both insurance companies and physicians.

According to CPT guidelines, fracture care may be reported to the insurance company as a “packaged” service. This means that at the time of initial care, a claim is generated that **includes** the following work/services:

1. The application of the first cast or splint
2. 90 days of normal, uncomplicated, follow-up care.

These services are **not included** in the fee associated with the fracture are billed separately:

1. X-rays (initial and follow-up)
2. All casting supplies (including those used in the first cast or splint)
3. Replacement cast application for medical necessity
4. Evaluation and management of any additional problems or injuries

There will be a separate charge for these and any appropriate co-payments, deductibles or co-insurances may apply.

Note: Cast replacements that are not for medical necessity may be denied by your insurance company and may be billed to you, the patient or guarantor of service.

If you have any questions, please do not hesitate to contact the office at 541-207-0910.

Patient Signature _____