Osteoporosis Fracture Care Preventing
Quick Coding Guide

AAOS
American Academy of Orthopaedic Surgeons

Despite decades of evidence and guidelines, osteoporosis treatment rates remain flat and there is a gap in care. The window immediately after a fragility fracture is identified/treated is a missed opportunity for prevention and long-term care that both patients and orthopedic surgeons can benefit from. Physicians can choose the level of engagement they are comfortable with and can establish protocols by creating a workflow for medications, follow-ups, labs, patient counseling and systemize the process by utilizing Advanced Practice Practitioners (APPs). As evaluation and treatment systems become more comprehensive, they are sometimes referred to as a Fracture Liaison Service (FLS). Coding already exists to support this work, and the result is comprehensive patient care and revenue success.

Common Myths	Facts
× You cannot bill separately for osteoporosis care in the global period	✓ Yes, because you are treating a different condition, you can bill a separate E&M service with Modifier 24
× You must prescribe osteoporosis medicine yourself	✓ No, you can refer/initiate instead
× Too much effort, low yield	✓ Use protocols and APPs – simple and easy!
× Doesn't pay	✓ E&M + coordination = worthwhile

Importance of treatment needed

Statistics illustrate:

- 1 in 3 women, 1 in 5 men will have osteoporosis[i]
- 2 million fragility fractures per year in US[ii]
- Only ~20-25% of patients with fragility fractures are treated for osteoporosis[iii, iv]
- The greatest single risk factor for a fragility fracture is having had one[v]

Benefits of treatment

All "major osteoporotic fractures" benefit from treatment, such as low energy, hip, spine, wrist, shoulder fractures define osteoporosis regardless of Bone Mineral Density (BMD) studies.

- Fracture risk reduced 30–70% with appropriate treatment[v, vi]
- Treatment reduces repeat fractures, cost, morbidity[i,v]

Examples of types of services*	
Baseline lab work:	• 25-OH Vitamin D, CMP (Ca^{2}+, Cre, Albumin), PTH, TSH
Order DEXA scan:	• Do not need before starting bisphosphonates, but useful to establish treatment response
Calcium supplementation + diet counselling:	• Equivalent Calcium carbonate or calcium citrate to 1500mg BID as long as no history of nephrolithiasis
Vitamin D supplementation:	• Above 30: 1,000 IU D3 QD • 15-30: 2,000 D3 IU QD • Below 15: 50,000 D3 IU qw x 12 weeks
Prescription medication management	• Prescription Strength Vitamin D supplementation (50,000 IU Vit D2 only) • Antiresorptive / bisphosphonate • Other anabolic bone medications

**Does not represent an exhaustive list*

When to refer to endocrine specialist

- Poor renal function (e.g., GFR < 40) or history of nephrolithiasis
- Esophageal contraindications
  - Achalasia
  - Barrett's
  - Esophageal stricture
  - Esophageal varices
- Gastric bypass
- History of prior antiresorptive use ("bisphosphonate failure")

Different options of involvement

Option 1: Counsel patients about osteoporosis
Option 2: Counsel + initiate workup (labs, DEXA scan)
Option 3: Counsel + initiate workup + initiate treatment

Appropriate Codes for Reporting Osteoporosis Fracture Care Counseling

- Surgical procedures and fracture care codes have 90-day global period
  - Includes all related Evaluation & Management (E&M) services
  - APP's associated with the practice[1] generally cannot bill separately during a global period – lumped in
- **Append Modifier 24,** *Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period,* **to appropriate E&M** code
- Allows bypass of the Global Period bundling of procedure
- **Modifier 24 Requires documentation**

New Diagnosis/ICD-10-CM:

- **Pitfall** – do not establish diagnosis of osteoporosis with fragility fracture prior to surgery
  - Leads to denial/bundling
- **M85.8** – Osteopenia not otherwise specified – good presumptive diagnosis
- **M80.xx** – Age-related osteoporosis with current pathological fracture
  - Use *only* once diagnosis is established, after surgery/treatment is initiated

Documentation Requirements:

- Specific language for:
  - Independent Interpretation of DEXA scan
  - Chronic Condition with Exacerbation or Progression
    - Not at treatment goal
  - Medication Management
    - More than just prescription given
- Same office note, same provider in EMR – need -24 modifier and appropriate diagnosis

Different Settings

Private Practice (small/medium)	• Initial Care driven by Treating MD +/- APP • Further Care generally by referral back to MD/Endocrine
Private Practice (large group)	• Initial Care driven by Treating MD +/- APP • May be able to set up telemedicine or in-person referral to NP or Consulting Endocrine – keep within system as separate reimbursement driver
Health System/Academic	• Either triggered referral through EMR • Or Initial Care driven by Treating MD • Or Initial Care kept within Ortho department • Subsequent referral pathways within system

[1] *CPT definition: "the exact same specialty and subspecialty who belongs to the same group practice"*

First Office Visit for Fracture

Sample workflow #1

- Discussion with Patient
  - This fracture –may- represent a fragility fracture
  - Biggest risk for further fragility fractures is having had one before
  - Have you had a DEXA scan in the last few years?
    - If yes, decide whether to repeat
  - Check labs as well
- Order DEXA scan
- Order CMP, Vit D, TSH, PTH
- Plan to follow up 1-2 weeks to review
- With ortho physician or with APP
- ICD-10: M85.8

Coding: E/M Level IV (moderate MDM)

Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

**Source: CPT®2025 Manual*

Sample workflow #2:

- Review DEXA scan with patient
  - Explain Z-score vs T-score
  - Confirm whether fracture is representative of a Fragility Fracture
    - If so, change ICD-10 to M80.xx
  - DOCUMENT AS INDEPENDENT INTERPRETATION
- Order labs
- Review Labs with patient
- Management:
  - Surveillance
  - Vit D/Ca++ supplementation
  - Referral to PCP or Endocrine or "Bone Health Team"
  - Initiate Bisphosphonate

Coding: E/M Level 4 (Moderate MDM)

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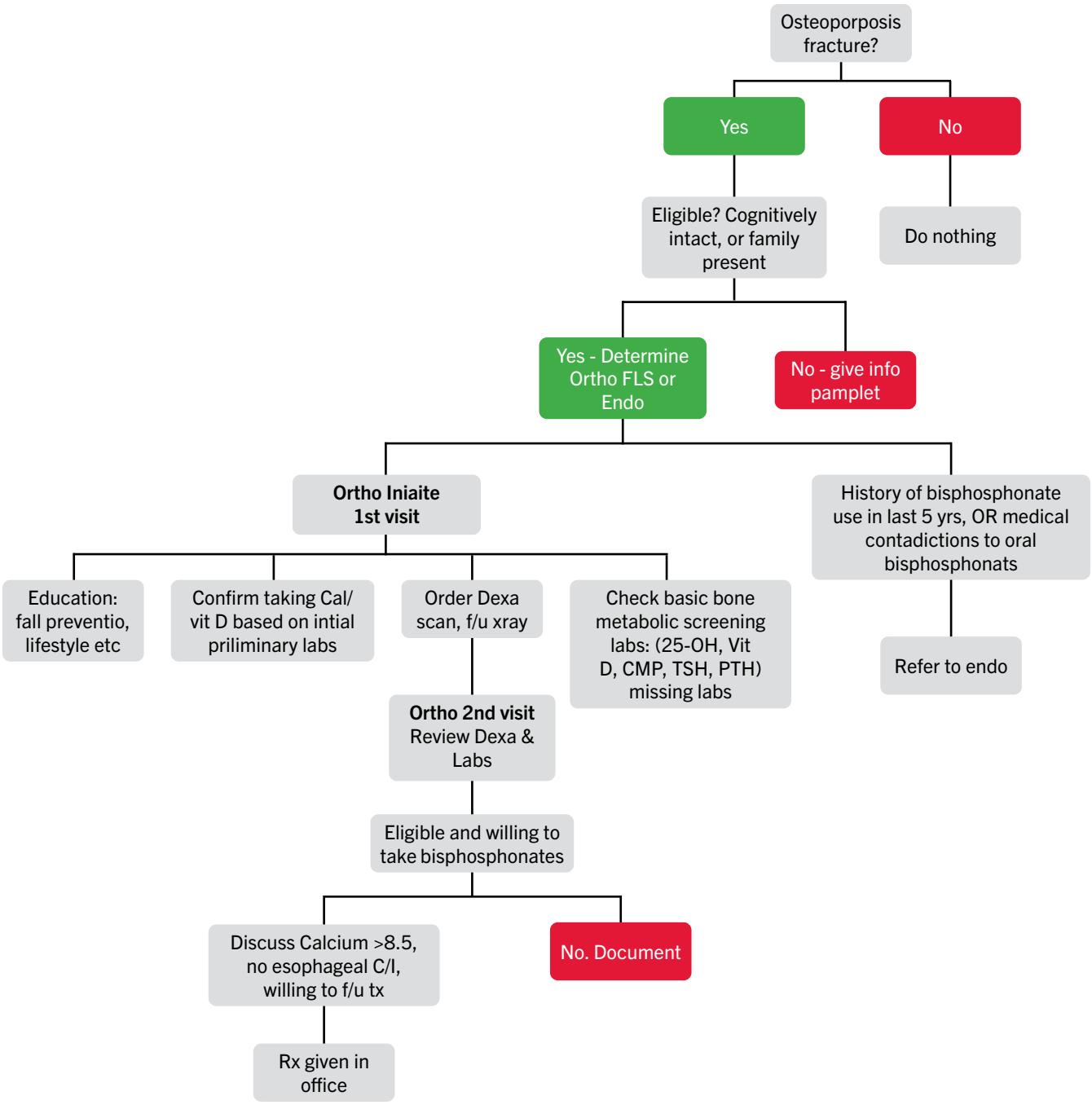
Example of Clinical Decision Tree for Treatment of Patients with Possible Osteoporotic Fractures



[i] Osteoporosis. Morin SN, Leslie WD, Schousboe JT. JAMA. 2025;:2835762. doi:10.1001/jama.2025.6003.

[ii] Epidemiology of Fracture Risk With Advancing Age. Ensrud KE. The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences. 2013;68(10):1236-42. doi:10.1093/gerona/glt092.

[iii] Antiosteoporosis Medication Prescriptions After Fragility Fractures. Silverstein WK, Wang S, Alavinejad M, et al.JAMA Network Open. 2024;7(10):e2438393. doi:10.1001/jamanetworkopen.2024.38393.

[iv] Trends in Osteoporosis Drug Therapy Receipt Among Commercial and Medicare Advantage Enrollees in the United States, 2011-2022. Everhart AO, Brito JP, Clarke BL, et al. The Journal of Clinical Endocrinology and Metabolism. 2025;:dgae840. doi:10.1210/clinem/dgae840.

[v] https://pubmed.ncbi.nlm.nih.gov/37566158/
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2827189?utm_source=openevidence&utm_medium=referral

[vi] Drug Therapy for Osteoporosis in Older Adults. Reid IR, Billington EO. Lancet (London, England). 2022;399(10329):1080-1092. doi:10.1016/S0140-6736(21)02646-5.

[vi] Fracture Risk Reduction and Safety by Osteoporosis Treatment Compared With Placebo or Active Comparator in Postmenopausal Women: Systematic Review, Network Meta-Analysis, and Meta-Regression Analysis of Randomized Clinical Trials. Händel MN, Cardoso I, von Bülow C, et al. BMJ (Clinical Research Ed.). 2023;381:e068033. doi:10.1136/bmj-2021-068033.