OMB control number: 0938-1146
Expiration date: 05/31/2026

Simple Fracture Guide

Label and Assumptions

Instructions to Plans and Issuers: Do not modify this table. The numbers shown here come from the Scenario table.

Table 1. Simple Fracture Sample Care Costs

Simple Fracture	Sample Care Costs
Other Facility Services	$43
Ambulance	$944
Emergency Department: Facility	$357
Professional Services: Emergency Department	$385
Professional Services: Specialist	$341
Professional Services: Physical Therapy	$364
Diagnostic Services: Radiology	$113
Durable Medical Equipment	$248
Prescription Drugs: Generic	$5
Total	**$2,800**

Assumptions

The following are assumptions that all group health plans and insurance issuers must use for this scenario. These assumptions are standard across all scenarios.

- Costs do not include premiums.
- Condition was not excluded as a pre-existing condition.
- There are no other medical expenses for any member covered under the plan or policy.
- All care is in-network and considered first tier (or the tier associated with the lowest level of cost sharing), for those products that incorporate tiered provider networks.
- No out-of-network charges or any other variation in sample care costs.
- All services occur in same policy period.
- All prior authorizations were obtained.
- All services were deemed medically necessary.
- All costs (allowed amount, sample care costs, member costs) greater than $100 are rounded to the nearest hundred.
- All costs (allowed amount, sample care costs, member costs) less than $100 are rounded to the nearest ten.
- If applying the rounding rules causes the cost sharing amount displayed to exceed the actual out-of-pocket limit (for self-only coverage), then the cost sharing amount must be capped and the amount of the actual out-of-pocket limit must be used. For example, if the out-of-pocket limit is $5,000 but applying the rounding rules makes the sum of the deductible, copayment and coinsurance equal to $5,100, the plan or issuer must use the out-of-pocket limit of “$5,000” and not “$5,100.” This amount (the $5,000 out-of-pocket limit) must then be added to the monetary amount in the exclusions and limits to determine the total *Patient pays* amount.

- All medications are covered as generic equivalents if available.
- If the plan has a wellness program that varies the deductibles, copayments, coinsurance, or coverage for any of the services listed in a treatment scenario, the plan or issuer must complete the calculations for that treatment scenario assuming that the patient is NOT participating in the wellness program.

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Scenario

Medical Condition: Simple Fracture

Note: Services are listed individually for classification and pricing purposes to facilitate the population of the “Sample care costs” section. HHS specifies the Category in order to roll up costs into that category in the "Sample care costs" section so that those costs are uniform across all group health plans and health insurance issuers. However, some plans or issuers may classify an item or service under another category. The plan or issuer should apply its cost sharing and benefit features for each plan or policy in order to complete the “You pay” section, but must leave as is the "Sample care costs" section. Examples of cost sharing and benefit features include, but are not limited to:

- Payment of services based on the location such as inpatient, outpatient, or office; and
- Payment of items as prescription drugs vs. medical equipment.

Explanation of Scenario

- Total – the sum of allowed amounts for the listed items and services, which is cross-referenced in the "Label and Assumptions" tab, where it is rounded.
- Date of Service – includes the day and month of service so plans and issuers understand the order in which items or services are rendered.
- ICD-10 Diagnosis Code – includes the ICD-10 code for each item or service.
- CPT, HCPCS or Other Billing Code – includes medical codes for each item or service. Over-the-counter medications are listed as OTC.
- Provider Type – includes one of the types listed on the "Provider Types" tab to classify each item or service by provider.
- Category – includes one of the categories listed on the "Categories" tab to classify each item or service so it rolls up into the same category in the "Label and Assumptions" tab.
- Description – includes the short form descriptor for a CPT code, or an appropriate descriptor for a non-CPT billing code.
- Allowed Amount – includes an estimated national average allowed amount for each item or service, which plans or issuers must use to calculate cost sharing.

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Table 2. Simple Fracture Scenario Timeline

Date of Service	ICD-10 Diagnosis Code	CPT©, HCPCS, or Other Billing Code	Provider Type	Category	Description	Allowed Amount
Totals:						$2,800.17
2-Jun	S99929A	A0425	Ambulance (land)	Ambulance	Ground mileage, per statute mile	$161.71
2-Jun	S99929A	A0429	Ambulance (land)	Ambulance	Ambulance service, basic life support, emergency transport (bls-emergency)	$782.16
2-Jun	S92355A	99283	Outpatient Hospital	Emergency Department: Facility	Emergency department visit for evaluation and management of patient, which req 3 key components. Usually, presenting problem(s) are moderate severity.	$357.31
2-Jun	S92355A	73630	Outpatient Hospital	Professional Services: Emergency Department	Radiologic examination, foot; complete, minimum of 3 views	$49.72
2-Jun	S92355A	28470	Outpatient Hospital	Professional Services: Emergency Department	Closed treatment of metatarsal fracture; without manipulation, each	$335.16
2-Jun	S92355A	L4361	Outpatient Hospital	Durable Medical Equipment	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf	$211.56
2-Jun		E0114	Pharmacy Retail	Durable Medical Equipment	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips	$35.97
2-Jun		00093015010	Pharmacy Retail	Prescription Drugs: Generic	Week supply of Acetaminophen 300 MG / Codeine Phosphate 30 MG Oral Tablet	$5.24

Date of Service	ICD-10 Diagnosis Code	CPT©, HCPCS, or Other Billing Code	Provider Type	Category	Description	Allowed Amount
9-Jun	S92355A	99203	Outpatient Hospital	Professional Services: Specialist	Office or other outpatient visit for the evaluation and management of a new patient, which requires at least 3 key components. Physicians typically spend 30 minutes face-to-face with the patient.	$127.51
9-Jun	S92355A	73630	Outpatient Hospital	Diagnostic Services: Radiology	Radiologic examination, foot; complete, minimum of 3 views	$49.72
9-Jun	S92355A	29405	Outpatient Hospital	Professional Services: Specialist	Application of short leg cast (below knee to toes)	$132.03
9-Jun	S92355A	Q4038	Outpatient Hospital	Other Facility Services	Cast supplies, short leg cast, adult (11 years +), fiberglass	$43.22
14-Jul	S92355A	73610	Primary	Diagnostic Services: Radiology	X-ray of ankle, minimum of 3 views	$63.18
14-Jul	S92355A	99213	Primary	Professional Services: Specialist	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	$81.66
4-Aug	S92355A	97001	Physical Therapy	Professional Services: Physical Therapy	Physical therapy evaluation	$116.43
11-Aug	S92355A	97110	Physical Therapy	Professional Services: Physical Therapy	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	$82.53

Date of Service	ICD-10 Diagnosis Code	CPT©, HCPCS, or Other Billing Code	Provider Type	Category	Description	Allowed Amount
11-Aug	S92355A	97110	Physical Therapy	Professional Services: Physical Therapy	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	$82.53
18-Aug	S92355A	97110	Physical Therapy	Professional Services: Physical Therapy	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	$82.53

** Inpatient costs were calculated based on national averages using the indicated DRG codes. Additional variances may occur based on how health plan hospital contracts are structured (e.g., case rate, per diems, percentage of billed charges, etc.)

Provider Types

The following are the provider types to use in the “Scenario” table ~ "Provider Type" column to classify each service by provider type. This aids group health plans and health insurance issuers in applying benefits to each item and service.

Table 3. Simple Fracture Provider Types

Provider Type	What providers are covered under this Provider Type and other notes:
Ambulance (land)	
Outpatient Hospital	
Pharmacy Retail	
Primary	
Physical Therapy	

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Categories

The following are the categories to use in the “Scenario” table ~ "Category" column to classify each item and service so it rolls up to the same category in the Coverage Example label in the "Label and Assumptions" table. This facilitates consistency between the "Scenario" table and Coverage Example label.

Table 4. Simple Fracture Categories

Category	What services are covered under this Category and other notes:
Ambulance	
Emergency Department: Facility	
Professional Services: Emergency Department	
Other Facility Services	
Durable Medical Equipment	
Professional Services: Specialist	
Professional Services: Radiology	
Professional Services: Physical Therapy	
Prescription Drugs: Generic	

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