INGENIX®

Coding Companion for Orthopaedics—Lower: Hips & Below

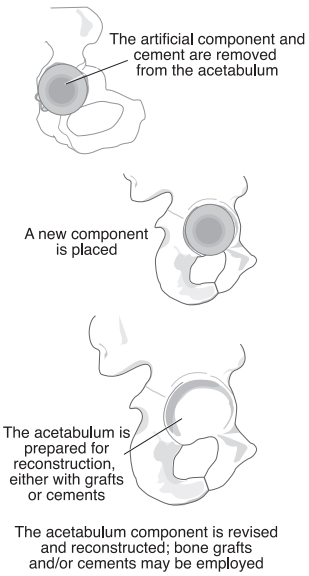
A comprehensive illustrated guide to coding and reimbursement

2009

Contents

27137

27137 Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft



Explanation

The physician revises a total hip arthroplasty. With the patient in a lateral decubitus position, the physician accesses the acetabular component through a previous hip surgery incision. Muscles are reflected. The physician may perform an osteotomy of the greater trochanter with an oscillating saw. The capsule is incised and the hip manually dislocated. Any scar tissue is removed from around the acetabulum. The physician removes cement from around the acetabular component with chisels and gouges. The acetabulum is levered out from its bed. The acetabulum may need to be reamed out in preparation for the new component. The physician reconstructs the acetabulum with or without cement. If the acetabulum is reconstructed without cement, the component is usually inserted and fixed with screws. Prior to the acetabulum placement, the physician may harvest a bone graft from the patient's iliac crest and close the surgically created graft donor site. Donor bone (allograft) may be used instead. If cement is used, it secures the new component in the acetabular bed. Once the cement has dried, the hip is reduced and the capsule closed. The physician may place suction drains in the wound. The incision is repaired in layers with sutures, staples, and/or Steri-strips.

Coding Tips

Bone graft harvest is not reported separately. For revision of a total hip arthroplasty, femoral component only, see 27138. For partial hip replacement, prosthesis (e.g., femoral stem prosthesis, bipolar arthroplasty), see 27125. For revision of a total hip arthroplasty, with both the acetabular and femoral components, see 27134. For initial arthroplasty, both components, see 27130. For removal of a hip prosthesis, without concurrent revision/replacement, see 27090–27091.

ICD-9-CM Procedural

00.71 Revision of hip replacement, acetabular component

00.73 Revision of hip replacement, acetabular liner and/or femoral head only

00.74 Hip bearing surface, metal-on-polyethylene

00.75 Hip bearing surface, metal-on-metal

00.76 Hip bearing surface, ceramic-on-ceramic

00.77 Hip bearing surface, ceramic-on-polyethylene

Anesthesia

27137 01215

ICD-9-CM Diagnostic

357.1 Polyneuropathy in collagen vascular disease — (Code first underlying disease: 446.0, 710.0, 714.0)

446.0 Polyarteritis nodosa

710.0 Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)

710.1 Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)

710.2 Sicca syndrome

714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)

714.33 Monoarticular juvenile rheumatoid arthritis

715.15 Primary localized osteoarthrosis, pelvic region and thigh

715.25 Secondary localized osteoarthrosis, pelvic region and thigh

715.35 Localized osteoarthrosis not specified whether primary or secondary, pelvic region and thigh

716.05 Kaschin-Beck disease pelvic, region and thigh

716.15 Traumatic arthropathy, pelvic region and thigh

718.05 Articular cartilage disorder, pelvic region and thigh

718.15 Loose body in pelvic joint

718.25 Pathological dislocation of pelvic region and thigh joint

718.35 Recurrent dislocation of pelvic region and thigh joint

731.3 Major osseous defects — (Code first underlying disease: 170.0-170.9, 730.00-730.29, 733.00-733.09, 733.40-733.49, 996.45)

733.14 Pathologic fracture of neck of femur

996.41 Mechanical loosening of prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)

996.42 Dislocation of prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)

996.43 Prosthetic joint implant failure — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)

996.44 Peri-prosthetic fracture around prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69.

996.45 Peri-prosthetic osteolysis — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69. Use additional code to identify major osseous defect, if applicable: 731.3)

996.46 Articular bearing surface wear of prosthetic joint — (Use additional code to identify prosthetic joint with mechanical complication, V43.60-V43.69)

CCI Version 14.3

20240-20245, 20610, 20670-20680, 20900-20902, 27001, 27005-27006, 27030, 27033, 27036-27041, 27052-27054, 27062-27067, 27086-27087, 27090-27091, 27120-27125, 27130, 27132❖, 27140, 27151, 27165-27170, 27187, 27220-27222, 27226-27228, 27246-27248, 27500, 27502, 27507, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 64712, 69990, 73530, 90760, 90765, 90772, 90774, 90775

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
27137	38.97	38.97	90	80

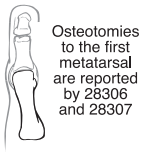
Medicare References: None

28306-28308

28306 Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal

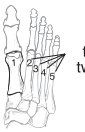
28307 first metatarsal with autograft (other than first toe)

28308 other than first metatarsal, each



Osteotomies to the first metatarsal are reported by 28306 and 28307

First metatarsal bone (great toe) is cut (osteotomy)



Osteotomies to metatarsals two through five are reported by 28308

Report 28307 when an autograft from an area other than the first metatarsal is used to reconstruct the first metatarsal

A general osteotomy is performed on the first metatarsal, with or without lengthening or other corrections. Report 28307 when an autograft from bone other than the first metatarsal is used. Report 28308 for an osteotomy to any other metatarsal bone

Explanation

A dorsomedial incision is made over the big toe and the skin and soft tissues are reflected back. In many cases this procedure is performed in an effort to correct the poor alignment of the big toe. In addition to removal of the medial eminence, a cut is made through the metatarsal shaft and a portion of the bone is removed in order to correct the alignment of the bone. Wires are used to reattach the bone in its corrected alignment. Sutures are used to close the incision. Weight bearing is protected for several weeks. Report 28307 if a bone graft is used to correct the alignment of the first metatarsal shaft and attached with wire or screws. Report 28308 if the procedure is performed on other metatarsal bones.

Coding Tips

Code 28307 should be reported only when a bone graft is obtained through a separate incision from a site other than the osteotomy site. Use of a bone graft from the osteotomy site is included in 28306. For osteotomy involving multiple metatarsal bones, see 28309. For radiology services, see 73600–73630.

ICD-9-CM Procedural

77.28 Wedge osteotomy of tarsals and metatarsals

77.38 Other division of tarsals and metatarsals

77.79 Excision of other bone for graft, except facial bones

78.08 Bone graft of tarsals and metatarsals

78.18 Application of external fixator device, tarsals and metatarsals

78.28 Limb shortening procedures, tarsals and metatarsals

78.38 Limb lengthening procedures, tarsals and metatarsals

84.53 Implantation of internal limb lengthening device with kinetic distraction

84.54 Implantation of other internal limb lengthening device

Anesthesia

01480

ICD-9-CM Diagnostic

357.1 Polyneuropathy in collagen vascular disease — (Code first underlying disease: 446.0, 710.0, 714.0)

359.6 Symptomatic inflammatory myopathy in diseases classified elsewhere — (Code first underlying disease: 135, 140.0-208.9, 277.30-277.39, 446.0, 710.0, 710.1, 710.2, 714.0)

446.0 Polyarteritis nodosa

710.0 Systemic lupus erythematosus — (Use additional code to identify manifestation: 424.91, 581.81, 582.81, 583.81)

710.1 Systemic sclerosis — (Use additional code to identify manifestation: 359.6, 517.2)

710.2 Sicca syndrome

714.0 Rheumatoid arthritis — (Use additional code to identify manifestation: 357.1, 359.6)

715.17 Primary localized osteoarthrosis, ankle and foot

715.97 Osteoarthrosis, unspecified whether generalized or localized, ankle and foot

718.47 Contracture of ankle and foot joint

719.47 Pain in joint, ankle and foot

726.91 Exostosis of unspecified site

727.1 Bunion

733.91 Arrest of bone development or growth

733.99 Other disorders of bone and cartilage

735.0 Hallux valgus (acquired)

735.1 Hallux varus (acquired)

735.2 Hallux rigidus

735.3 Hallux malleus

735.4 Other hammer toe (acquired)

735.5 Claw toe (acquired)

735.8 Other acquired deformity of toe

736.79 Other acquired deformity of ankle and foot

754.50 Congenital talipes varus

754.52 Congenital metatarsus primus varus

754.53 Congenital metatarsus varus

754.59 Other congenital varus deformity of feet

754.60 Congenital talipes valgus

754.71 Talipes cavus

755.38 Congenital longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency)

755.67 Congenital anomalies of foot, not elsewhere classified

Terms To Know

autograft. Any tissue harvested from one anatomical site of a person and grafted to another anatomical site of the same person. Most commonly, blood vessels, skin, tendons, fascia, and bone are used as autografts.

osteotomy. Surgical cutting of a bone.

CCI Version 14.3

01470, 11012❖, 20550-20553, 28020, 28090-28092, 28220-28226, 29540, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 90760, 90765, 90772, 90774, 90775, J2001

Also not with 28306: 28234, 28315, 29425

Also not with 28307: 20900-20902, 28234, 28306, 28315

Also not with 28308: 28110, 28485, 29405-29425, 29515

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
28306	10.77	14.75	90	30
28307	12.13	17.36	90	80
28308	9.85	13.34	90	30

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient and instructions and