INGENIX®

Coding Companion for Orthopaedics—Lower: Hips & Below

A comprehensive illustrated guide to coding and reimbursement

Contents

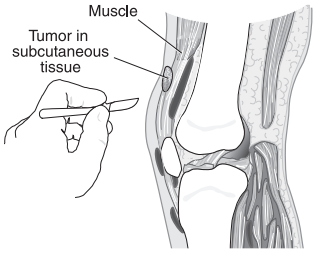
27327-27328 (27337, 27339)

27327 Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm

27328 Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm

27337 Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater

27339 Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater



Report 27327 or 27337 for subcutaneous excision and 27328 or 27339 for subfascial excision of a soft tissue tumor of the thigh or knee area

Explanation

The physician removes a tumor from the soft tissue of the thigh or knee area that is located in the subcutaneous tissue in 27327 and 27337 and in the deep soft tissue, below the fascial plane, or within the muscle in 27328 and 27339. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 27327 for excision of a subcutaneous tumor whose resected area is less than 3 cm, and 27337 for excision of a subcutaneous tumor that is 3 cm or greater. Report 27328 for excision of a subfascial or intramuscular tumor whose resected area is less than 5 cm, and 27339 for excision of a subfascial or intramuscular tumor that is 5 cm or greater.

Coding Tips

Codes 27337 and 27339 are new for 2010. They are resequenced codes and will not display in numeric order. Codes 27327 and 27328 have been revised for 2010 in the official CPT description. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient.

ICD-9-CM Procedural

83.31 Excision of lesion of tendon sheath

83.32 Excision of lesion of muscle

83.39 Excision of lesion of other soft tissue

83.49 Other excision of soft tissue

86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue

86.4 Radical excision of skin lesion

Anesthesia

27327 00400

27328 01320

27337 00400

27339 01320

ICD-9-CM Diagnostic

171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip

172.7 Malignant melanoma of skin of lower limb, including hip

173.7 Other malignant neoplasm of skin of lower limb, including hip

195.5 Malignant neoplasm of lower limb

198.89 Secondary malignant neoplasm of other specified sites

209.34 Merkel cell carcinoma of the lower limb

209.75 Secondary Merkel cell carcinoma

214.1 Lipoma of other skin and subcutaneous tissue

214.8 Lipoma of other specified sites

215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip

228.1 Lymphangioma, any site

238.1 Neoplasm of uncertain behavior of connective and other soft tissue

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

782.2 Localized superficial swelling, mass, or lump

Terms To Know

graft. Tissue implant from another part of the body or another person.

lymphangioma. Benign, malformed lymph channels.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.

CCI Version 15.3

01250, 01320, 10060, 10140, 10160, 20610, 27306-27307, 27306-27310❖, 29445, 29870-29871, 29871, 29874, 29876-29883, 29885-29887, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 27327: 11011-11012❖, 12001-12007, 12020-12037, 13120-13121, 27323-27325, 27340-27345, 38500, J2001

Also not with 27328: 11012❖, 11401, 11404, 12001-12007, 12020-12037, 13120-13121, 20680, 27325, 27327, 27340-27345, 27372, 64712

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
27327	8.46	11.82	90	N/A
27328	16.2	16.2	90	N/A
27337	11.32	11.32	90	80
27339	20.39	20.39	90	80

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

11900-11901

11900 Injection, intralesional; up to and including 7 lesions

11901 more than 7 lesions

Explanation

The physician uses a syringe to inject a pharmacologic agent underneath or into seven or fewer skin lesions in 11900 and more than seven lesions in 11901. The lesions may be any healed skin lesions including post-laceration and post-surgical scar bands. The physician may inject steroids or anesthetics (not pre-operative local anesthetic) into these lesions.

15734

15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk

Explanation

The physician repairs a defect area using a muscle and skin or a fascia and skin flap. The physician rotates the prepared flap from the donor area to the site needing repair, suturing the flap in place. The donor area is closed primarily with sutures. If a skin graft or flap is used to repair the donor site, it is considered an additional procedure and is reported separately.

15944-15945

15944 Excision, ischial pressure ulcer, with skin flap closure;

15945 with ostectomy

Explanation

The physician excises an ischial pressure ulcer, with skin flap closure. An incision is made around the wound over the ischial tuberosity in order to remove the infected pressure sore. The infected tissue is removed; however, the wound is large enough to require a flap of skin from another part of the body, such as the groin area at the front of the hip, to completely close the area. The physician makes an appropriate size flap from the donor area and sutures it in place following the removal of the infected tissue. The donor site is sutured closed and soft dressings are used to cover the wounds. Report 15945 if a portion of bone from the ischium is removed before the wound is closed with the flap.

17000-17004

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

17003 second through 14 lesions, each (List separately in addition to code for first lesion)

17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions

Explanation

The physician destroys or excises premalignant lesions using a laser, electrosurgery, cryosurgery, chemical treatment, or surgical curettement. Local anesthesia is included. Report 17000 when one lesion is destroyed and 17003 when two to 14 lesions are destroyed.

17110-17111

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

17111 15 or more lesions

Explanation

The physician uses a laser, electrosurgery, cryosurgery, chemical treatment, or surgical curettement to obliterate or vaporize benign lesions other than skin tags or cutaneous vascular proliferative lesions. Report 17110 for 14 lesions or less and 17111 for 15 or more lesions.

17260-17264

17260 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less

17261 lesion diameter 0.6 to 1.0 cm

17262 lesion diameter 1.1 to 2.0 cm

17263 lesion diameter 2.1 to 3.0 cm

17264 lesion diameter 3.1 to 4.0 cm

Explanation

The physician destroys a malignant lesion of the trunk, arms, and legs. Destruction may be accomplished by using a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion, chemicals to destroy the lesion, or surgical curettement to remove the lesion. Report 17260 for a lesion diameter 0.5 cm or less; 17261 for 0.6 cm to 1 cm; 17262 for 1.1 cm to 2 cm; 17263 for 2.1 cm to 3 cm; 17264 for 3.1 cm to 4 cm; and 17266 if the lesion diameter is greater than 4 cm.

17270-17276

17270 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less

17271 lesion diameter 0.6 to 1.0 cm

17272 lesion diameter 1.1 to 2.0 cm

17273 lesion diameter 2.1 to 3.0 cm

17274 lesion diameter 3.1 to 4.0 cm

17276 lesion diameter over 4.0 cm

Explanation

The physician destroys a malignant lesion of the scalp, neck, hands, feet, or genitalia. Destruction may be accomplished by using a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion, chemicals to destroy the lesion, or surgical curettement to remove the lesion. Report 17270 for a lesion diameter 0.5 cm or less; 17271 for 0.6 cm to 1 cm; 17272 for 1.1 cm to 2 cm; 17273 for 2.1 cm to 3 cm; 17274 for 3.1 cm to 4 cm; and 17276 if the lesion diameter is greater than 4 cm.

35400

35400 Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)

Explanation

The purpose of this procedure is to use an endoscope to look inside a blood vessel. The physician places an introducer sheath in the vessel to be examined, using percutaneous puncture or a cutdown technique. The physician places an angioscopy catheter through the introducer sheath into the vessel to be examined. The physician advances the angioscope through the vessel, clearing the view with injections of saline. Once the inside of the vessel has been examined, the angioscope and sheath are withdrawn. Vessel hemostasis is achieved using sutures or manual pressure.

69990

69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)

Explanation

The physician uses a surgical microscope when the services are performed using the techniques of microsurgery, except when the microscopy is part of the procedure (such as in 15756). This code is reported in addition to the primary procedure.

72170

72170 Radiologic examination, pelvis; 1 or 2 views

Explanation

One or two views are taken of the pelvis. The most common view is from front to back (AP) with the patient lying supine with feet inverted 15 degrees to overcome the anteversion (or rotation) of the

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 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, instructions, and