Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Scenarios Help You Perfect Your Orthopedic ICD-9 Coding Skills

Tip: Let the surgeon determine whether the condition is acute vs. chronic.

If you choose the wrong code for subluxations/dislocations, lingering pain, or acute/chronic conditions, you could face a denial and potentially cost your practice time and money.

Check out the following three scenarios. Our experts will identify problem areas and then offer the solutions that will help hone your ICD-9 coding.

Pick Apart Subluxation, Dislocation Terminology

Scenario 1: Your orthopedist saw an infant with developmental dislocation of the hip (DDH). He documented the baby's problem with the terms subluxation and dislocation. Your ICD-9 book doesn't include a diagnosis code for DDH. You do have separate subluxation and dislocation diagnosis codes, however.

Problem: What is the difference between subluxation and dislocation? And which code applies more?

Solution: First, you need to dig into your terminology.

Subluxation: Subluxation describes a partial or incomplete dislocation, meaning that the patient has suffered partial loss of the joint's congruency. This is an incomplete or partial dislocation, says **Kristi Stumpf, MCSP, CPC, COSC, ACS-OR,** compliance and coding supervisor for Proliance Orthopedics and Sports Medicine in Bellevue, Wash. A subluxation can occur due to ligamentous laxity."

Dislocation: Dislocation is the complete removal of the joint from the socket. This is a complete displacement of the bone from its articulation, Stumpf says. This involves disruption of the capsule and/or supporting ligaments.

Key: If the patient suffered congenital subluxation, he most likely had an inborn laxity or prestretching of the ligaments and/or attaching musculotendinous groups or attachments, which do not allow a total disjointing of the femoral head. Therefore, the patient did not experience a complete dislocation.

Your best coding choice for this condition would probably be 754.32 (Congenital subluxation of hip, unilateral) for unilateral DDH, or 754.33 (Congenital subluxation of hip, bilateral) if both the patient's hips were affected.

Long-Term Pain Means Avoiding This ICD-9 Chapter

Scenario 2: Your orthopedist recently performed a rotator cuff repair, and his notes document the patient has suffered pain over nine months.

Problem: When you go to report the patient's pain, you cannot find coding guidelines describing when to report 840.4 (Sprains and strains of shoulder and upper arm; rotator cuff [capsule]) versus 726.10 (Disorders of bursae and tendons in shoulder region, unspecified) or 727.61 (Nontraumatic complete rupture of rotator cuff). Should you not report an acute injury for this service?

Solution: You should not report an acute injury code. Code 840.4 is from the injury chapter of the ICD-9 guidebook. In your case, the patient didnt suffer an injury.

The patient experienced nine months of pain that warranted the procedure. You should append the most definitive codes

that are appropriate for the condition your physician treats, says **Patrice A.Young, CPC, CMSCS,** senior coder at Commonwealth Orthopedic Associates in Reading, Penn.

Therefore, you should avoid 840.4 and select another code based on the rest of the orthopedist's documentation, such as 727.61, instead.

How to Upgrade Acute to Chronic Conditions

Scenario 3: A patient suffers a rotator cuff strain from lifting boxes at his job. Your orthopedist sees the patient for several months. Eventually, your orthopedist determines the patient actually has a torn rotator cuff that requires surgery to repair.

Problem: How should you differentiate an acute injury from a chronic one? Can the patient upgrade from an acute condition to a chronic one?

Solution: First, find what acute versus chronic means.

Acute: An acute condition is sudden and severe. Typically, an acute injury is an injury that occurred within the past 90 days, says **Melanie Uitto, CPC, COSC,** supervisor of coding compliance at the Center for Orthopedic Research and Education (CORE) Institute in Sun City West, Ariz.

The Centers for Disease Control's National Center for Health Statistics publishes the following definition of an acute condition"An acute condition is a type of illness or injury that ordinarily lasts less than three months, was first noticed less than three months before the reference data of the interview, and was serious enough to have had an impact on behavior."

You could assign 840.4 initially to denote the acute injury.

Chronic: A chronic condition is a longer developing syndrome, persistent, continuing, or recurring,but may have been caused by an acute injury. Although a single event may be a final straw, generally the patient's symptoms have been occurring for a long time," Stumpf says.

List the patient's current condition -- the complete rotator cuff rupture (727.61) -- as the primary diagnosis. You should assign 905.7 (Late effect of sprain and strain without mention of tendon injury) as the secondary code to help create a connection between the two conditions.

As for upgrading an acute condition to a chronic one, this depends on the insurance company. Physicians conservatively treat acute conditions, such as rotator cuff strains, and patients respond well with no further treatment. Sometimes, however, the conservative treatment fails, and the patient requires surgery after all, at which point the condition would be upgraded to a chronic one. This could take as long as a year, experts say.

Watch out: Even acute tears are usually acute exacerbations of chronic tears. Therefore, surgeons feel that the number of tendons the patient tears has nothing to do with which CPT code the surgeon selects.

Best bet: Leave the determination of acute versus chronic up to the surgeon. If an ICD-9 or CPT code forces you to differentiate between whether the patient's condition is acute or chronic, show both descriptors to the surgeon and ask him to decide.