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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Combat Hip Coding Confusion With a Few Simple Expert Tips

Understand eponyms, acronyms and unlisted-procedure coding rules to make your claims sparkle

Don't let hip coding challenges get your reimbursement processes out of joint. Today we-ll address the three most common hip coding questions, along with expert advice that will make your claims sparkle.

Stick With 1 Unlisted-Procedure Code per Claim

CPT includes four hip arthro-scopy codes (29860-29863), but unfortunately, not every hip procedure falls into that series. For example, suppose your physician performs the following procedures:

- right hip arthroscopy with labral debridement
- right hip arthroscopy with anterior capsulotomy
- right hip arthroscopy with femoral neck osteoplasty.

For the first procedure, you-ll report 29862 (Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage [chondroplasty], abrasion arthroplasty, and/or resection of labrum), says **Melanie Uitto, CPC, CMC**, coder at the CORE Institute in Sun City West, Ariz.

But both the second and third procedures require you to use unlisted-procedure code 29999 (Unlisted procedure, arthroscopy). The problem is that you can report each unlisted-procedure code only once per claim, according to CPT rules.

The April 2001 CPT Assistant states, -When performing two or more procedures that require the use of the same unlisted code, the unlisted code used should only be reported once to identify the service provided. This is due to the fact that the unlisted code does not identify a specific unit value or service. Unit values are not assigned to unlisted codes since the codes do not identify usual procedural components or the effort/ skill required for the service.-

Therefore, you-ll bill 29999 just once, along with an op report and a letter from the surgeon describing what he performed.

-We highlight or make notes on the actual op report indicating where in the body of the op report the unlisted procedure is being described,- Uitto says.
You should select a value for the unlisted services by adding the values of your -compare codes- (such as the open hip surgery codes 27036 and 27161) and submit your proposed reimbursement to the insurer.

Compare, Contrast Hip Procedures

Coders often get confused when selecting codes for hip revisions and conversions because the op reports may be similar. When a total hip replacement (THR) fails and one or both of the components has to be revised, you-ll report a revision (27134, 27137 or 27138).

You-ll report a conversion to total hip (27132, Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft) when the patient has had a prior procedure, such as a hemiarthroplasty, and subsequently undergoes a total hip replacement.

When the physician performs a staged revision, you-ll also report 27132. During the first stage, the physician removes the implant and places a spacer (27091), and during the second stage, the physician removes the spacer and performs a reimplantation of THR components (27132).

You may apply 27125 (Hemi-arthroplasty, hip, partial [e.g., femoral stem prosthesis, bipolar arthroplasty]) and 27236 (Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement) to hemiarthroplasty, but under different circumstances. You-ll use 27236 when a fracture necessitates the surgery.

You-ll report 27125 for a partial new hip that the orthopedic surgeon puts in place due to osteoarthritis, osteonecrosis brought on by cortisone treatment, or another reason that might cause the hip to degenerate (but not a fracture), says **Heather Corcoran**, coding manager at CGH Billing in Louisville, Ky.