Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Miss Picking Up $258 More For Closed Hip Dislocation Treatments Requiring Anesthesia

Here's how to steer clear of traumatic hip dislocation's hidden traps.

To choose the proper code from 27250-27254, you need to look for certain elements -- anesthesia, trauma, and fracture, to name a few. But some are easier to spot than others. Here's how to avoid the common pitfalls traumatic hip dislocation coding presents.

27250/27252: Watch Anesthesia Requirements

Your first two coding options are 27250 (Closed treatment of hip dislocation, traumatic; without anesthesia) and 27252 (... requiring anesthesia).

Two requirements for these codes are fairly straightforward. Both codes are for (1) closed treatment and (2) traumatic dislocations.

Gray area: Coders often encounter trouble deciding whether the treatment qualifies as "requiring anesthesia" because of the different types, including general anesthesia and conscious sedation.

Different sources have different opinions on what anesthesia refers to in code descriptors. An August 2005 AAOS Bulletin article describing 26340 (Manipulation, finger joint, under anesthesia, each joint) states that "the terms -under anesthesia- or -with anesthesia- are now understood to reflect the appropriate anesthesia for a given patient and/or given situation," rather than being limited to general anesthesia.

But that same year, CPT® Assistant (April 2005), referring to 23700 (Manipulation under anesthesia, shoulder joint, including application of fixation apparatus [dislocation excluded]), states that the "code descriptors, which include the phrase -requiring anesthesia- or -under anesthesia- indicate that the work involved in that specific procedure requires the use of general anesthesia." However, this is now an outdated definition. Orthopedists do shoulder replacements now under regional blocks (interscalene blocks) and can do similar things in the lower extremity, though not so much in the hip. Physicians can do epidural anesthesia for the hip.

Safe bet: Report 27252 only if the surgeon uses general anesthesia, unless your payer tells you in writing that this code is appropriate for other forms of anesthesia, as well. The National Physician Rate for 27252 is $395, while the National Physician Rate for 27250 is $137 □ that's a $258 difference. You don't want to miss out on that extra reimbursement when you deserve it -- and you don't want to have to pay it back for improper coding.

27253/27254: Catch Fracture, Ex Fix Blunders

Your next two options are open treatment codes for traumatic dislocations: 27253 (Open treatment of hip dislocation, traumatic, without internal fixation) and 27254 (Open treatment of hip dislocation, traumatic with acetabular wall and femoral head fracture, with or without internal or external fixation).

Again you should be able to narrow your options to these two codes easily by identifying two elements: open treatment and traumatic dislocation. But you need to be on your toes to distinguish dislocation alone (27253) from dislocation with fracture (27254).

Fractures and dislocations are under the same section in the CPT® book and some physicians call these "fracture/dislocation" in their dictation, experts say. You may need to seek clarification from the physician for proper

coding: "Is it a fracture, is it a dislocation, or both?"

Hint: The determining factor in the op note will be if the physician used screws and plates. Acetabular or femoral head fracture will almost always have something like this, while dislocations rarely require any hardware.

Don't miss: Both codes are appropriate for treatment without internal fixation, but 27254 states "with or without internal or external fixation." Translation: You should not report an external fixation code with 27254. Although CPT® changed many descriptors to allow you to bill external fixation (20690, 20692) separately with several other codes, CPT® includes fixation in 27254.

If you try to report the two together, your system should kick out the fixation code. The Correct Coding Initiative (CCI) edits bundle the external fixation codes into 27254.

835.XX: Follow These 5th Digit Clues

The ICD-9 manual groups your hip dislocation coding options into one handy group:

- 835.0X -- Dislocation of hip; closed dislocation
- 835.1X -- ... open dislocation.

You will see closed dislocations more often than open, but your surgeon should document which it is. If not, be sure to verify before coding.

Your fifth digit options are as follows:

- 0 -- - dislocation of hip, unspecified
- 1 -- - posterior dislocation
- 2 -- - obturator dislocation
- 3 -- - other anterior dislocation.

Your surgeon should document whether the dislocation is posterior, obturator, or another anterior type. If you don't have that information, ask for clarification.

Tip: Fifth digit "3" states "other anterior dislocation" because obturator dislocation is classified as an anterior dislocation, although it has distinct clinical indicators. The other anterior dislocations you may see (and use fifth digit "3" for) are iliac and pubic. But be prepared. The vast majority of dislocations are posterior, which may occur, for example, when the patient's knee hits the dashboard during a head-on collision.

Watch out: You have other ICD-9 options for nontraumatic hip dislocations.

Modifier 57: Succeed With E/M + Treatment

You'll see the majority of hip dislocations in the hospital or emergency department (ED), rather than in the office. If the ED doctor calls your surgeon to evaluate and treat the patient, you may report both an E/M and the treatment as long as the documentation reflects a separately identifiable E/M service.

Don't forget: You should append modifier 57 (Decision for surgery) to the E/M code.