Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Halt Your Hip Coding Headaches With These Helpful Hints

Stay away from 26992 or face denials

If you think you should report V54.81 for a hip replacement patient's follow-up visit, hold your horses. Discover why you need to consider other V-code options--and find out how Category III codes come into play.

Core Decompression Warrants Unlisted

Coders often wonder whether they're coding core decompression of the hip properly. Whereas some practices report 20225 (Biopsy, bone, trocar or needle; deep [e.g., vertebral body, femur]) for this service, others report 26992 (Incision, bone cortex, pelvis and/or hip joint [e.g., osteomyelitis or bone abscess]), and still others report the unlisted procedure code (27299).

Advice: In the January 2002 issue of CPT Assistant, the **American Medical Association** (AMA), which oversees CPT code assignments, advised coders to report 27299 (Unlisted procedure, pelvis or hip joint) for core decompression. CPT Assistant states, "Code 26992 should not be reported, as this does not accurately describe the core decompression procedure."

Warning: Not only does the AMA advise against reporting 26992, but a general coding rule dictates that you should never select a code simply because it's "close" to what your surgeon performed. "Selecting a code that is 'close' is not compliant coding," says **Marvel Hammer, RN, CPC, CHCO**, president of **MJH Consulting** in Denver. "Knowingly and willingly coding a service or procedure with a code for the explicit motivation of bypassing denials and ensuring payment is fraud. The documentation will not support the procedure being billed."

Do this: You should send the insurer a copy of your physician's operative notes with your core decompression claim. To determine a price for the procedure, compare your physician's work to the work involved in the biopsy procedure that 20225 describes.

Report V54.81 Only for Recovering Patients

If your physician examines a patient one year after her hip replacement and determines that she is in perfect health, which diagnosis code should you assign to the evaluation and management claim? "This is probably the number-one hip diagnosis question that people ask me," says **Randall Karpf**, president of **East Billing** in East Hartford, CT.

"When the new aftercare ICD-9 codes came out, people were very excited and started billing V54.81 (Aftercare following joint replacement) like crazy," Karpf says. "But you should only report V54.81 if the patient is still healing from the surgery."

Coding solution: If your asymptomatic patient presents to your practice for an annual visit following total hip replacement, you should report the appropriate E/M code (99211-99215 for established patients), along with V67.09 (Follow-up examination; following other surgery) and V43.64 (Organ or tissue replaced by other means; hip).

Use 0054T-0056T for CAD With Hip Revisions

Physicians perform about 14,000 total hip revisions on Medicare patients every year, and many physicians have tried to optimize results by using computer-assisted devices (CAD) to assist them in planning and executing these difficult

procedures. But coding--and collecting--for the CAD may prove difficult for coders.

You should report a category III code for these new guidance devices, such as VectorVision and the OEC FluoroTrak.

In 2004, CPT introduced three new codes for computer-assisted musculoskeletal surgical navigational orthopedic procedures:

• +0054T - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on fluoroscopic images (list separately in addition to code for primary procedure)

• +0055T - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on CT/MRI images (list separately in addition to code for primary procedure)

• +0056T - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, imageless (list separately in addition to code for primary procedure)

Even if your insurer recognizes category III codes (and most Medicare payors do not), many carriers consider computer-assisted navigational devices for orthopedic procedures investigational and non-payable.

Best bet: Ask your payors for their 0054T policies before you bill. When you do submit your claim, include a copy of your operative notes and a letter from the physician describing how the CAD equipment enhances surgical outcomes.

Insurers who recognize 0054T may take longer to process these claims, because insurance representatives must review them manually.

Get More Answers To Your Stickiest Hip Surgery Questions

Still unsure about how to code for femur injuries and hip joint debridement? Well, you're not alone. Our readers are feeling your pain and want to end confusion, too. Here's what you need to know to get your claims right the first time.

How Many Codes Describe Hip Joint Debridement?

Question 1: Our patient suffered a severe hip joint infection following total hip arthroplasty, so the surgeon performed hip arthrotomy, then debrided and irrigated the wound. Can he bill both 11044 and 27030, or should he just bill 27030?

Answer: The answer depends on whether the surgeon debrided bone, or just tissue and/or muscle. If the surgeon does not document bone debridement, you should not report 11044 (Debridement; skin, subcutaneous tissue, muscle, and bone).

Because the physician did not document bone debridement, you're left with debridement code choices of 11040-11043. But "the American Academy of Orthopaedic Surgery's Global Service Data indicates that 'debridement, excisional, of soft tissue (e.g., 11040-11043) is included in 27030 (Arthrotomy, hip, with drainage [e.g., infection])," says **Tracy E. Wheeler, CPC**, coder at **Albany Orthopedic Center** in Albany, GA.

When the physician performs debridement along with hip arthrotomy or other surgeries, "there must be clear documentation that he performed more than the normal amount of debridement during the procedure," says **Susan Vogelberger, CPC, CPC-H, PMCC** instructor and business office coordinator for the **Orthopaedic Surgery Center** at **Beeghly Medical Park** in Ohio. "Otherwise, I would not code the debridement separately."

In other words, reimbursement for the arthrotomy inherently includes any debridement that the physician performs in the immediate area of the surgical wound. If, however, the debridement necessitated extension of the incision and/or addressed a separate area, you could separately report a debridement code.

If you perform the arthrotomy during the global period of the original hip arthroplasty, you should append modifier 78

(Return to the operating room for a related procedure during the postoperative period) to 27030, Wheeler says.

When Does a Femur Injury Warrant a Hip Fx Code?

Question 2: Our orthopedic surgeon documented a fracture to the intertrochanteric region of the femur. Should we report a hip fracture ICD-9 code or a femur fracture code? I'm not sure when a femur fracture becomes a hip fracture.

Answer: Before you assign an ICD-9 code, the physician must indicate which bony component of the hip your patient fractured (for example, the femoral head, femoral neck, acetabulum, etc).

"Generally speaking, a hip fracture refers to a fracture of the neck or intertrochanteric portion of the proximal femur," Wilson says. "True femur fractures usually involve the femur below the level of the lesser trochanter in the mid shaft area."

If your physician specifically notes a fracture to the intertrochanteric region, you should report the appropriate code from the femoral neck section of ICD-9.

If the patient had a closed fracture, report 820.21 (Fracture of neck of femur; pertrochanteric fracture, closed; intertrochanteric section). If the patient had an open fracture, however, choose 820.31 (... pertrochanteric fracture, open; intertrochanteric section).