Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Help - Don't Hinder - Your Total Hip Replacement Recording By Following This Expert Advice

Never skip the underlying cause, infections, or dislocations.

If you're overlooking the underlying cause for the replacement surgery and any infections or dislocations in the replaced hip, then you could be leaving precious dollars your physician ethically deserves on the table.

Read on to gain more insight into how to identify and code these aspects of this common procedure to recoup your full earned reimbursement.

Underlying Cause is Paramount

If you overlook the diagnosis when reporting hip replacements, you're omitting an important reimbursement component. This is especially so in cases where the hip replacement is being done for a congenital or developmental hip dislocation. These cases are often complicated enough to allow you to append modifier 22 (Increased procedural services) to the claim to recoup payment for your surgeon's work on these cases.

"Make sure your surgeon documents any additional work and also the undue time spent on any such case. The medical record documents should support his additional work," says Leslie A. Follebout, CPC, COSC, senior orthopaedic coder and auditor with The Coding Network.

A diagnosis alone does not support the medical necessity of reporting a 22 modifier. The documentation must clearly indicate that the procedure was more complex than the normal and why," says Ruby **O'Brochta-Woodward, BSN, CPC, CCS-P, COSC, ACS-OR**, compliance and research specialist for Twin Cities Orthopedics, P.A.

Watch for this: The underdeveloped acetabulum in a developmental hip dislocation calls for advanced techniques to be used and complex implants to be used. The modifier works only if supported by documentation. There may be anatomical changes that lead to significant increased complexity when dealing with congenital or developmental deformities. The operative report would need to clearly support the use of the modifier 22.

Capture Infection, Dislocation Interventions

Keep in mind that infections can occur after hip replacement surgeries, and you may need to report any that necessitated intervention.

Example: You may read that your surgeon did an arthrotomy and debridement for infection after a total hip replacement. In this case, you report 27030 (Arthrotomy, hip, with drainage [eg, infection]). Also note that you will need to ascertain the extent of the debridement before you report one. Debridement and excision of soft tissues are inclusive in 27030.

If the arthrotomy is done during the global period of the original hip replacement procedure, you append modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) to 27030. You cannot report 11042 (Debridement, subcutaneous tissue [includes epidermis and dermis, if performed]; first 20 sq cm or less) or 11043 (Debridement, muscle and/or fascia [includes epidermis, dermis, and subcutaneous tissue, if performed]; first 20 sq cm or less) with the hip replacement code(s).

Exception: You may report debridement code(s) if your surgeon adequately documents that the debridement was

extensive enough to necessitate the extension of the incision or approach a separate area to allow proper drainage.

For instance: Here is another common example for return of a patient in the global period. A patient, who had undergone a total hip replacement, overextended the leg, and her prosthesis dislocated. The surgeon returns the patient to the operation theatre and reduces the dislocation.

In this case, you report 27266 (Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia). You should also append modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period). It may be necessary to indicate that another procedure if it occurred during the global period. You also report the diagnosis code 996.42 (Dislocation of prosthetic joint). You also report V43.64 (Hip joint replacement).

Cases with prior surgeries are a coding challenge when it comes to reporting the additional procedures like removal of hardware.

ICD-10: When your diagnosis system changes, you should shift to T84.020A (Dislocation of internal right hip prosthesis, initial encounter) or T84.021A (Dislocation of internal left hip prosthesis, initial encounter) instead of 996.42. You also have unspecified options, but you should always report to the highest specificity. For V43.64, you should refer to the following diagnoses instead:

- Z96.641 – Presence of right artificial hip joint
- Z96.642 – Presence of left artificial hip joint
- Z96.643 – Presence of artificial hip joint, bilateral
- Z96.649 – Presence of unspecified artificial hip joint.

Example: You may have an op note that indicates a patient with "femoral neck fracture was treated with open reduction with internal fixation;" your surgeon diagnoses a nonunion and performs right hip hemiarthroplasty. You may read in the operative note that your surgeon did an adductor tenotomy and removed the hardware. In this case, you confirm with your payer and report 27125 (Hemiarthroplasty, hip, partial [eg, femoral stem prosthesis, bipolar arthroplasty]) for the hemiarthroplasty and 27001 (Tenotomy, adductor of hip, open) and 20680 (Removal of implants; deep [e.g., buried wire, pin, screw, metal band, nail, rod or plate]). You may append modifier 59 (Distinct Procedural Service) with CPT® 20680 and modifier 51 (Multiple Procedures) with 27001, if required.

"But if your patient is a Medicare primary, you cannot report 20680 in addition to 27125 according to CCI guidelines," says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

In addition: You may read that your surgeon, when doing the THR, used a polarizating microscope to identify crystals or examined the under a microscope to confirm the diagnosis of the underlying condition, you do not additionally report these procedures as the code(s) for the hip replacement include these services.