Coding Companion for Orthopaedics—Lower: Hips & Below

A comprehensive illustrated guide to coding and reimbursement

2016

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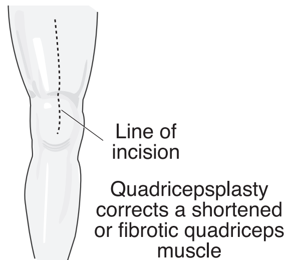
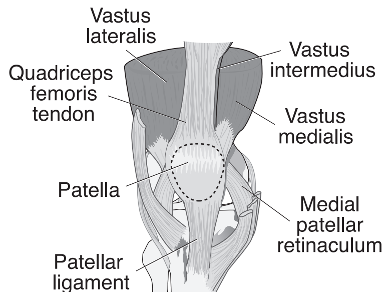
27430

27430 Quadricepsplasty (eg, Bennett or Thompson type)





Explanation

The physician corrects a shortened or fibrotic quadriceps muscle. An anterior longitudinal incision is made from the upper one third of the thigh to the lower part of the patella. Deep fascia is divided and the rectus femoris muscle is separated from the vastus medialis and lateralis muscles. The vastus intermedius muscle is excised because it is usually scarred and is binding the posterior surface of the rectus femoris and patella to the femur. If the vastus medialis and lateralis muscles are badly scarred, subcutaneous tissue and fat are interposed between them and the rectus. If these muscles are relatively normal, they are sutured to the rectus at the lower one third of the thigh. Layers and incisions are closed with sutures and staples or Steri-strips.

Coding Tips

This procedure is performed on the quadriceps muscle. Muscles included in the quadriceps are the rectus femoris, vastus intermedius, vastus medialis, and vastus lateralis. This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). When 27430 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51.

ICD-9-CM Diagnostic

713.8 Arthropathy associated with other conditions classifiable elsewhere — (Code first underlying disease as conditions classifiable elsewhere except as in: 711.1-711.8, 712, 713.0-713.7)

718.46 Contracture of lower leg joint

890.1 Open wound of hip and thigh, complicated

HCPCS Equivalent Codes

N/A

Terms To Know

anterior. Situated in the front area or toward the belly surface of the body; an anatomical reference point used to show the position and relationship of one body structure to another.

complication. Condition arising after the beginning of observation and treatment that modifies the course of the patient's illness or the medical care required, or an undesired result or misadventure in medical care.

contracture. Shortening of muscle or connective tissue.

excise. Remove or cut out.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

incision. Act of cutting into tissue or an organ.

posterior. Located in the back part or caudal end of the body.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
27430	21.13	21.13	90	A	1(2)

	Modifiers				Medicare Reference
27430	51	50	62*	80	None

* with documentation

Femur/Knee

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11900-11901

11900 Injection, intralesional; up to and including 7 lesions
11901 more than 7 lesions

Explanation

The physician uses a syringe to inject a pharmacologic agent underneath or into any diagnosed skin lesion. Steroids, anesthetics (excluding preoperative local anesthesia), or any non-chemotherapy pharmacological agent may be injected. Report 11900 for injection of seven or fewer lesions. Report 11901 when more than seven lesions are treated.

15734

15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk

Explanation

The physician repairs a defect area using a muscle and skin or a fascia and skin flap. The physician rotates the prepared flap from the donor area to the site needing repair, suturing the flap in place. The donor area is closed primarily with sutures. If a skin graft or flap is used to repair the donor site, it is considered an additional procedure and is reported separately.

15944-15945

15944 Excision, ischial pressure ulcer, with skin flap closure;
15945 with ostectomy

Explanation

The physician excises an ischial pressure ulcer, with skin flap closure. An incision is made around the wound over the ischial tuberosity in order to remove the infected pressure sore. The infected tissue is removed; however, the wound is large enough to require a flap of skin from another part of the body, such as the groin area at the front of the hip, to completely close the area. The physician makes an appropriate size flap from the donor area and sutures it in place following the removal of the infected tissue. The donor site is sutured closed and soft dressings are used to cover the wounds. Report 15945 if a portion of bone from the ischium is removed before the wound is closed with the flap.

17000-17004

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003 second through 14 lesions, each (List separately in addition to code for first lesion)
17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions

Explanation

The physician destroys or excises premalignant lesions using a laser, electrosurgery, cryosurgery, chemical treatment, or surgical curettement. Local anesthesia is included. Report 17000 when one lesion is destroyed and 17003 when two to 14 lesions are destroyed.

17110-17111

17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111 15 or more lesions

Explanation

The physician uses a laser, electrosurgery, cryosurgery, chemical treatment, or surgical curettement to obliterate or vaporize benign lesions other than skin tags or cutaneous vascular proliferative lesions. Report 17110 for 14 lesions or less and 17111 for 15 or more lesions.

17260-17266

17260 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5 cm or less
17261 lesion diameter 0.6 to 1.0 cm
17262 lesion diameter 1.1 to 2.0 cm
17263 lesion diameter 2.1 to 3.0 cm
17264 lesion diameter 3.1 to 4.0 cm

Explanation

The physician destroys a malignant lesion of the trunk, arms, and legs. Destruction may be accomplished by using a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion, chemicals to destroy the lesion, or surgical curettement to remove the lesion. Report 17260 for a lesion diameter 0.5 cm or less; 17261 for 0.6 cm to 1 cm; 17262 for 1.1 cm to 2 cm; 17263 for 2.1 cm to 3 cm; 17264 for 3.1 cm to 4 cm; and 17266 if the lesion diameter is greater than 4 cm.

17270-17276

17270 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
17271 lesion diameter 0.6 to 1.0 cm
17272 lesion diameter 1.1 to 2.0 cm
17273 lesion diameter 2.1 to 3.0 cm
17274 lesion diameter 3.1 to 4.0 cm
17276 lesion diameter over 4.0 cm

Explanation

The physician destroys a malignant lesion of the scalp, neck, hands, feet, or genitalia. Destruction may be accomplished by using a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion, chemicals to destroy the lesion, or surgical curettement to remove the lesion. Report 17270 for a lesion diameter 0.5 cm or less; 17271 for 0.6 cm to 1 cm; 17272 for 1.1 cm to 2 cm; 17273 for 2.1 cm to 3 cm; 17274 for 3.1 cm to 4 cm; and 17276 if the lesion diameter is greater than 4 cm.

35400

35400 Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)

Explanation

The purpose of this procedure is to use an endoscope to look inside a blood vessel. The physician places an introducer sheath in the vessel to be examined, using percutaneous puncture or a cutdown technique. The physician places an

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Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $33.5 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under "Instructions for Use of the CPT Codebook" on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase "physician or other qualified health care professional" (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)." State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from "clinical staff" and are able to practice independently. CPT defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient's encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient's attending

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