INGENIX®

Coding Companion for Oncology/Hematology

A comprehensive illustrated guide to coding and reimbursement

2009

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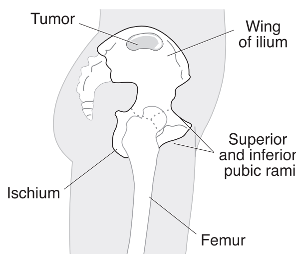
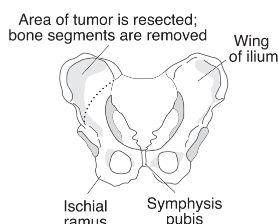
27075

27075 Radical resection of tumor or infection; wing of ilium, 1 pubic or ischial ramus or symphysis pubis





Explanation

The patient is positioned for a lithotomy with the buttock elevated. For resection (excision) of the pubis and/or ischium, an incision is made from the pubic tubercle to the ischial tuberosity. The adductor and obturator muscles are detached from the pubis and ischium. Additional dissection is carried down to better expose the pubis and ischium. The remaining muscles and ligaments are released (freed by incision) while the pudendal and genital nerves and vessels are protected. The bone(s) is separated and cut with bone-cutting forceps and an osteotome or saw. The bone segments are removed. A separate incision is made to resect the ilium. As above, the portion of the ilium needing resection is dissected out by releasing muscles, tendons, and ligaments. The incisions are repaired in layers.

Coding Tips

If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. A biopsy is not identified separately when followed by an excisional removal during the same operative session. For excision of a bone cyst or benign tumor, deep, see 27066; with autograft requiring separate incision, see 27067. For radical resection of a tumor or an infection, pelvic bones, see 27075-27079.

ICD-9-CM Procedural

77.89 Other partial ostectomy of other bone, except facial bones

Anesthesia

27075 01170

ICD-9-CM Diagnostic

170.6 Malignant neoplasm of pelvic bones, sacrum, and coccyx

170.7 Malignant neoplasm of long bones of lower limb

198.5 Secondary malignant neoplasm of bone and bone marrow

213.7 Benign neoplasm of long bones of lower limb

238.0 Neoplasm of uncertain behavior of bone and articular cartilage

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

707.00 Pressure ulcer, unspecified site — (Use additional code to identify pressure ulcer stage: 707.20-707.25)

707.04 Pressure ulcer, hip — (Use additional code to identify pressure ulcer stage: 707.20-707.25)

707.09 Pressure ulcer, other site — (Use additional code to identify pressure ulcer stage: 707.20-707.25)

715.15 Primary localized osteoarthrosis, pelvic region and thigh

716.15 Traumatic arthropathy, pelvic region and thigh

730.15 Chronic osteomyelitis, pelvic region and thigh — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)

730.35 Periostitis, without mention of osteomyelitis, pelvic region and thigh — (Use additional code to identify organism: 041.1)

730.85 Other infections involving bone diseases classified elsewhere, pelvic region and thigh — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)

731.3 Major osseous defects — (Code first underlying disease: 170.0-170.9, 730.00-730.29, 733.00-733.09, 733.40-733.49, 996.45)

996.66 Infection and inflammatory reaction due to internal joint prosthesis — (Use additional code to identify specified infections. Use additional code to identify infected prosthetic joint: V43.60-V43.69)

996.67 Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft — (Use additional code to identify specified infections)

996.77 Other complications due to internal joint prosthesis — (Use additional code to identify complication: 338.18-338.19, 338.28-338.29)

Terms To Know

decubitus ulcer. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off caused by continual pressure to a localized area, especially over bony areas, where blood circulation is cut off when a patient lies still for too long without changing position.

forceps. Tool used for grasping or compressing tissue.

ischial tuberosity. Bony projection of the lower end of the ischium easily identified as the weight-bearing point in a sitting position.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

osteotome. Tool used for cutting bone.

periostitis. Inflammation of the outer layers of bone.

ulcer. Open sore or excavating lesion of skin or the tissue on the surface of an organ from the sloughing of chronically inflamed and necrosing tissue.

CCI Version 14.3

10060, 10140, 10160, 20680, 26990-26992, 27005-27006, 27030, 27033, 27036-27054, 27060-27071, 27086-27087, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 73530, 90760, 90765, 90772, 90774, 90775

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
27075	60.24	60.24	90	80

Medicare References: None

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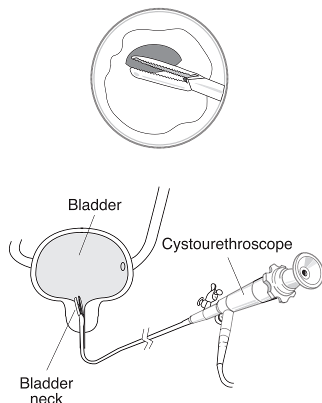
52640

52640 Transurethral resection; of postoperative bladder neck contracture



Explanation

Contracture of the bladder neck outlet usually results from scarring after a transurethral resection of the prostate gland. After preliminary cystourethroscopy, the physician passes the resectoscope under direct vision up the urethra to the region of the bladder neck contracture. Meatotomy, cutting to enlarge the opening of the urethra, and dilation of the urethra may be necessary to allow the passage of the resectoscope. The scar tissue is incised at one to three sites or resected, using a cutting electrocautery knife. The operative site is inspected for bleeding, which is controlled by fulguration. A catheter is passed into the bladder at the end of the procedure and let in place for the postoperative period.

Coding Tips

If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. For transurethral resection of postoperative obstructive tissue, see 52630. For transurethral resection of the bladder neck, see 52500.

ICD-9-CM Procedural

57.49 Other transurethral excision or destruction of lesion or tissue of bladder

Anesthesia

52640 00914

ICD-9-CM Diagnostic

596.0 Bladder neck obstruction — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)

598.2 Postoperative urethral stricture — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)

599.60 Urinary obstruction, unspecified — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39)

599.69 Urinary obstruction, not elsewhere classified — (Use additional code to identify urinary incontinence: 625.6, 788.30-788.39. Code, if applicable, any causal condition first: 600.0-600.9, with fifth-digit 1)

788.20 Unspecified retention of urine — (Code, if applicable, any causal condition first, such as: 600.0-600.9, with fifth digit 1)

788.21 Incomplete bladder emptying — (Code, if applicable, any causal condition first, such as: 600.0-600.9, with fifth digit 1)

788.29 Other specified retention of urine — (Code, if applicable, any causal condition first, such as: 600.0-600.9, with fifth digit 1)

788.30 Unspecified urinary incontinence — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.31 Urge incontinence — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.32 Stress incontinence, male — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.33 Mixed incontinence urge and stress (male)(female) — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.34 Incontinence without sensory awareness — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.35 Post-void dribbling — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.36 Nocturnal enuresis — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.37 Continuous leakage — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.38 Overflow incontinence — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

788.39 Other urinary incontinence — (Code, if applicable, any causal condition first: 600.0-600.9, with fifth digit 1; 618.00-618.9; 753.23)

Terms To Know

contracture. Shortening of muscle or connective tissue.

dilation. Artificial increase in the diameter of an opening or lumen made by medication or by instrumentation.

electrocautery. Division or cutting of tissue using high-frequency electrical current to produce heat, which destroys cells.

fulguration. Destruction of living tissue by using sparks from a high-frequency electric current.

male stress incontinence. Involuntary escape of urine in men at times of minor stress against the bladder, such as coughing, sneezing, or laughing.

nocturnal enuresis. Bed-wetting.

resection. Surgical removal of a part or all of an organ or body part.

urge incontinence. Involuntary escape of urine coming from sudden, uncontrollable impulses.

CCI Version 14.3

00910, 00914-00916, 36000, 36410, 37202, 51701-51703, 52000-52001, 52276, 52281, 52283, 52450-52500❖, 53600-53621, 53853❖, 55873❖, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 90760, 90765, 90772, 90774, 90775, P9612

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
52640	8.71	8.71	90	N/A

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

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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 $29 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.

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
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- 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'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 within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call for or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient and instructions and

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