Orthopedics Concepts

The ICD-10 Success Series
Webconference
November 12, 2014
Managing your Audio

**Use Telephone**

If you select the “use telephone” option, please dial the phone number and access code provided.

**Use Microphone and Speakers**

If you select the “Use Mic & Speakers” option, please be sure that your speakers/ head phones are connected.
How to Submit Questions to Our Panelists

Use the GoTo Webinar Question Panel to Ask a Question

Enter a Question in the Question Panel

Type your question and hit send

The presenter may answer the question here or respond verbally
Managing your Screen

To minimize the control panel

- Click the orange button with the white arrow
  - Minimizes the control panel to the right side of your screen
  - Re-opens the control panel

To maximize the presentation area..

- The blue button with the white square will maximize the presentation to fill your screen
Brief Overview: The ICD-10 Success Series Webconferences

Across the coming months, the Advisory Board’s Clinical Advisor Team will be hosting numerous Webconferences on a variety of documentation topics critical to a seamless and successful transition to ICD-10. As providers, please take a look at the list of upcoming sessions and save time to attend those most pertinent to your practice. We have created them to be succinct and to the point, and will be presenting lessons you can begin to incorporate into your documentation immediately (in an ICD-9 world). Below is a list of all upcoming sessions:

1. September 24th – Sepsis/Septicemia
2. October 1st – UTI
3. October 8th – Pressure Ulcers
4. October 15th – Stroke
5. October 22nd – Encephalopathy
6. October 29th – AMI & Coronary Artery Disease
7. November 5th – Respiratory Failure, Pneumonia, COPD
8. **November 12th** – Orthopedic Surgery, Joints, Spine
9. November 19th – Diabetes
10. December 3rd – Anemia
11. December 10th – Cellulitis
12. December 17th – Ambulatory

**All sessions will be hosted from 12:00 – 1:00 pm EST. Recordings will be made available for follow up viewing on the intranet and physician websites.**
About Today’s Speaker

Dan Avstreih, MD FACEP

- Medical Director at the Advisory Board Company
- Board certified physician in Emergency Medicine
- Since 2006, Dr. Avstreih has practiced at an ultra high-volume, tertiary care/level 1 trauma emergency department in Northern Virginia
- Dr. Avstreih holds clinical professor appointments at both the Virginia Commonwealth School of Medicine and the George Washington University School of Medicine
- Dr. Avstreih is an Associate Medical Director of the largest fire-rescue department in Virginia, overseeing the emergency medical care of more than 1.1 million citizens
- Serves in emergency management roles for both Northern Virginia and the National Capital Region.

For more information, contact:

Dan Avstreih, MD, FACEP
Medical Director
202.266.5600
AvstreiD@advisory.com
Brief Overview: Code Expansion in ICD-10 Requires Greater Documentation Specificity

Expanded Code Set in ICD-10: ~16K to ~150K

Why So Many New Codes?

The main difference between ICD-9 and ICD-10 codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10 codes specify several components not found in ICD-9, such as stage, laterality, severity, root cause operation, etc.

Key ICD-10 Concepts Required in Documentation

<table>
<thead>
<tr>
<th>Stage or grade of disease</th>
<th>Severity: mild, moderate, severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific anatomical location</td>
<td>Episode of care: initial vs. subsequent</td>
</tr>
<tr>
<td>Acute or chronic</td>
<td>Unilateral or bilateral condition</td>
</tr>
</tbody>
</table>
Road Map for Discussion

1. Key Concepts To Capture in Your Documentation

2. Examples of Orthopedic Diagnoses and Procedures in ICD-10

3. Upcoming Sessions
Concepts Drive Changes in Documentation Requirements

Key Considerations for Orthopedic Surgery: ICD-10-CM

- Laterality
- Causal Agent
- Infection Site
- Type of Underlying Disease
- Type of Disc Disorder
- Encounter
- Complication
- Type of Bone Disorder
Concepts Drive Changes in Documentation Requirements

Key Considerations for Orthopedic Surgery: ICD-10-PCS

- Laterality
- Site of Replacement
- Type of Device
- Insertion Site
- Root Operation
- Destruction Site
- Excision Site
- Quantity
- Operation
Linking Conditions Critical to Capturing Patient Severity in ICD-9 and 10

There is a significant increase in the number of “combination codes” available in the ICD-10–CM code set. These codes can help capture the highest level of complexity and acuity in publicly reported data.

Linking clinically relevant conditions, where appropriate, is the key takeaway physicians need to incorporate into their documentation today. Remember, coders cannot assume such clinical relationships.

Examples: Linking Diseases

• Pathologic fracture of L-4 vertebrae due to osteoporosis
• Stress fracture of pelvis with malunion
• Septic arthritis of right knee due to staph aureus

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
Road Map for Discussion

1. Key Concepts to Capture in Your Documentation

2. Examples of Orthopedic Diagnoses and Procedures in ICD-10

3. Upcoming Sessions
# Topics Covered Today

Five Representative Orthopedic Diagnosis and Procedure Types Encompass Orthopedic Documentation Requirements for ICD-10-CM/PCS:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Fractures Documentation: Open &amp; Pathological Fractures</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Total Hip and Knee Replacement</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Open Reduction Internal Fixation (ORIF)</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Spinal Fusion</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Procedure Documentation</td>
</tr>
<tr>
<td>ICD-10-CM Fracture Documentation Concepts</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Specific Anatomical Location</strong></td>
<td><strong>Open¹ and Closed</strong></td>
</tr>
<tr>
<td>Displaced or Nondisplaced</td>
<td>Extension (Episode of Care)</td>
</tr>
<tr>
<td></td>
<td>(e.g. Initial, Subsequent, Sequelae)</td>
</tr>
<tr>
<td>Type (Severity):</td>
<td>Laterality</td>
</tr>
<tr>
<td>(e.g. Compound, Delayed Union, Depressed, Elevated, Greenstick, Impacted, Late Effects, Linear, Malunion, Missile, Nonunion, Oblique, Puncture, Segmental, Sequelae, Simple, Transverse, etc.)</td>
<td>(R/L/bilateral/unspecified)</td>
</tr>
<tr>
<td>Routine versus Delayed Healing</td>
<td>Nonunion and Malunion</td>
</tr>
<tr>
<td>List other related injuries</td>
<td>Specify any associated or underlying disease</td>
</tr>
<tr>
<td>(e.g. tendons, nerves, arteries, veins, etc.)</td>
<td>(e.g. osteoporosis)</td>
</tr>
<tr>
<td>Information regarding the activity, location, and circumstances surrounding the injury</td>
<td></td>
</tr>
<tr>
<td>(e.g. skiing accident on Boine Mountain)</td>
<td></td>
</tr>
</tbody>
</table>

¹) See Gustilo Classification System
# For Your Reference: Gustilo-Anderson Open Fractures Classification

Required ICD-10-CM Documentation for Open Fractures

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (e.g. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
</tr>
</tbody>
</table>
Traumatic “Open” Fracture

Displaced articular fracture of head of left femur, initial encounter for open fracture type I

Fracture of femur

Anatomic Site, Severity, (numerous options for anatomic site of femur fracture)

Laterality

Encounter (10 options for Open fractures)

Initial encounter for open fracture Type I or II

Articular fracture of the head femur

Displaced

Left

Fracture of femur
Pathological Fractures Comparison

ICD-10-CM Documentation Components for Pathological Fractures

- **Etiology**: osteoporosis, neoplastic, in other specified disease, drug induced NEC, unspecified etiology or NOS
- **Age of fracture**: New vs. Old
- **Specific Site**: Includes all ICD-9-CM options with the addition of hand & finger, shoulder, femur & pelvis, ankle, foot & toe
- **Laterality**: Right vs. Left
- **Encounter type**:
  - Initial
  - Subsequent
    - With routine healing
    - With delayed healing
    - Nonunion or malunion
  - Sequelae

*Note: Pathological fractures are critical to capture in order to relay patient acuity. Quality reporting organizations (such as healthgrades.com) will exclude cases with pathological fractures from certain metrics, understanding the inherent complexity this presents. Specificity of the site and/or underlying etiology can impact risk stratification by various quality organizations.*
Clinical Scenario: 85-year-old female broke her arm when she picked up a heavy shopping bag. In hospital, she was diagnosed with osteoporosis and broken right arm. Radiology study confirms closed fracture of the radius.

Age-related osteoporosis with current pathological fracture, right forearm, initial encounter for fracture

Osteoporosis with current pathological fracture

Documentation Takeaway:

The patient with osteoporosis who suffers a fracture should be specified as “osteoporosis with current pathological fracture,” and not “a traumatic fracture,” if the mild trauma or fall would not have caused a break in a normal healthy bone. Only the physician can determine if the trauma was significant enough to cause the break.
Total Joint Replacement Clinical Examples

Here are a few examples of cases you treat on a regular basis, as described using ICD-10-PCS terminology.

**Hip and Knee Replacement**

The “root” operation identifies the objective or intent of the procedure. These procedures are classified as **Replacement** when the biological or synthetic material completely takes the place and/or function of all or portion of the body parts.

*Note:* For partial hip and knee replacements, physician documentation of the specific surface they replaced is needed (e.g., the right acetabular surface of the left tibial surface) for the coder to accurately capture the code assignment.
Total Hip Replacement

The 6th character within the ICD-10-PCS procedure code will capture what type of Implant used.

Procedure Codes Capture type of Device Substitute Used

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>S</td>
<td>R</td>
<td>B</td>
<td>0</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Medical & Surgical  Lower Joints  Replacement  Hip Joint  Open  Synthetic Substitute, Metal on Polyethylene  Cemented

**Note:** A device is coded only if a device remains after the procedure is completed. If no device remains, (as with the use of a balloon pump) it will be coded as having “no device.”

**Remember:** If the type of graft is different between sites, a separate procedure will need to be documented.

**Device Options:**
- Synthetic Substitute, Metal
- Synthetic Substitute, Metal on Polyethylene
- Synthetic Substitute, Ceramic on Polyethylene
- Synthetic Substitute
- Autologous Tissue Substitute
- Nonautologous Tissue Substitute
ORIF: Technique (Approach) Used Captured Within Procedure Code

5th Character captures the technique used to reach the site of the procedure

Section | Body System | Root Operation | Body Part | Approach | Device | Qualifier
---|---|---|---|---|---|---
0 | Q | S | 6 | 0 | 4 | Z

- Medical & Surgical
- Lower Bones
- Reposition
- Upper Femur, right
- Open
- Internal Fixation
- No qualifier

Approach Options:
- Open
- Percutaneous
- Percutaneous Endoscopic
- External
Documentation Checklist for Spinal Fusion Procedures

Accurate documentation of spinal procedures requires greater specificity.

<table>
<thead>
<tr>
<th>Documentation Checklist for Spinal Fusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Objective of Procedure</strong></td>
</tr>
<tr>
<td>• Fusion</td>
</tr>
<tr>
<td><strong>2 Body Site for Procedure</strong></td>
</tr>
<tr>
<td>• Level of the spine (e.g. thoracic)</td>
</tr>
<tr>
<td>• Distinct body part/single vertebral joint</td>
</tr>
<tr>
<td>• Distinct body part/multiple vertebral joints</td>
</tr>
<tr>
<td><strong>3 Technique Used to Reach Procedure Site</strong></td>
</tr>
<tr>
<td>• Open</td>
</tr>
<tr>
<td>• Percutaneous</td>
</tr>
<tr>
<td>• Percutaneous endoscopic</td>
</tr>
<tr>
<td><strong>4 Device Placed</strong></td>
</tr>
<tr>
<td>• Autologous Tissue Substitute</td>
</tr>
<tr>
<td>• Nonautologous Tissue Substitute</td>
</tr>
<tr>
<td>• Interbody Fusion Device</td>
</tr>
<tr>
<td>• No Device</td>
</tr>
<tr>
<td><strong>5 Qualifier</strong></td>
</tr>
<tr>
<td>• Anterior Approach, Anterior Column</td>
</tr>
<tr>
<td>• Posterior Approach, Posterior Column</td>
</tr>
<tr>
<td>• Posterior Approach, Anterior Column</td>
</tr>
<tr>
<td>• No Qualifier</td>
</tr>
</tbody>
</table>
Spinal Fusion Documentation: How It All Comes Together

Appropriate documentation for each of the key considerations outlined on the previous page allow for accurate code assignment.

Representative Fusion of 2 to 7 Thoracic Vertebral Joints with Autologous Tissue Substitute, Posterior

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical &amp; Surgical</td>
<td>Upper Joints</td>
<td>Thoracic Vertebral Joints, 2-7</td>
<td>Open</td>
<td>Autologous Tissue Substitute</td>
<td>Posterior Approach, Anterior Column</td>
</tr>
<tr>
<td>R</td>
<td></td>
<td>Fusion 1</td>
<td>Objective of Procedure</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td></td>
<td>7</td>
<td>Body Site for Procedure</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>0</td>
<td>Technique Used to Reach Procedure Site</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>7</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Specification of Approach and Column</td>
<td></td>
</tr>
</tbody>
</table>
Ensure Complete Documentation when Multiple Vertebral Joints are Fused

If multiple vertebral joints are fused, ICD-10-PCS coding guidelines instruct coders to separately code these procedures for each vertebral joint that uses a different device and/or qualifier.

Procedures Must Be Documented and Coded Separately

Fusion of lumbar vertebral joint, posterior approach, anterior column

Fusion of lumbar vertebral joint, posterior approach, posterior column

• Spinal fusion documentation requires specification of approach (anterior/posterior) and column (anterior/posterior)
• Approach is typically documented; column is not.
Best Practice ICD-10-PCS Concepts To Include

Date/Time:
Procedure Intended:
Procedure Performed:
*(document reason for difference)*
Additional procedures performed:
*Procedure checklist:
Device Identified:
What made the procedure difficult/longer:
Unusual findings:
Complication:
  – Accidental or complication?
  – Due to:
    • Disease/condition
    • Patient characteristics
    • Surgery
    • Drugs

Procedure Checklist:
- Body system
- Root operation
- Body part
- Approach
- Devices
- Qualifier
- Common complications
ICD-10-CM coding terminology will change to more accurately identify when complications occur.

- ICD-10-CM has replaced the term post-operative with “post-procedural” or “post-surgical”
- Documentation of conditions occurring in the post-operative period should be clarified whether they are:
  - An expected post-procedural or post-surgical condition
  - An unexpected post-procedural or post-surgical condition, unrelated to surgical procedure
  - An unexpected post-procedural or post-surgical condition, related to the patient’s underlying medical comorbidities
  - An unexpected post-procedural or post-surgical condition related to surgical care (a complication of care)
# Documentation of Procedural Complications

Procedure notes should reflect any of the following regarding complications:

## Documentation Concepts

| Timing          | • Intraoperative  
|                | • Postprocedure   
|                | • Late effect    |
| Procedure       | • Aspiration, puncture, other   
|                | • Endoscopic exam   
|                | • Infusion, transfusion, injection   
|                | • Removal of a catheter or packing   
|                | • Medical procedure – Name It   |
| Associated with | • Accidental puncture/laceration   
|                | • Same or different system   
|                | • Blood products   
|                | • Central venous catheters   
|                | • Drugs:   
|                | • What adverse effect   
|                | • Drug name   
|                | • Correctly prescribed   
|                | • Properly administered   |

## Reminders:

- Often times the terms “post-surgical, post-procedural or post-operative” are a time stamp and not a complication of care. When this is the case, ensure it is clear in your documentation. Consider using language such as “expected post-operative anemia, blood loss within normal limits.”

- When documentation within the record is unclear, it is advised that the physician be queried.
Outpatient Procedures & ICD-10-PCS

Three Key Considerations To Remember When Documenting Procedures in the Outpatient Setting

1. ICD-10-PCS will only be used for capturing inpatient procedures.

2. If you perform an outpatient procedure on a patient who is admitted within 3 days, then that procedure is rolled into the inpatient admission if the admission is for a related diagnosis. Therefore, it is critical that your documentation in an outpatient environment is at the ICD-10 level of specificity.

3. Physician should document outpatient procedures to satisfy ICD-10-PCS, HCPCS and CPT requirements in case the patient is admitted as an inpatient.
Key Documentation Concepts

• Coding terminology for key procedure types will change with ICD-10-CM/PCS. Understand definitions to better recognize codes in your daily practice (problem lists, etc.)

• Always specify the type of device used (e.g., Synthetic Substitute, Autologous Tissue Substitute, Nonautologous Tissue Substitute, Interbody fusion device, type of prosthesis, etc.)

• Partial hip and knee replacements, documentation of the specific surface replaced is needed for accurate code assignment

• Documentation of the approach is required. The approach is the technique used to reach the site of the procedure (e.g., open, percutaneous, endoscopic, or external)

• When treating spinal fusions, specify level of the spine and whether single or multiple joints were involved

• Spinal fusion documentation also requires specification of approach (anterior/posterior) and column (anterior/posterior)

• Remember: Claim submission requires all 7 procedure characters be reported.
Road Map for Discussion

1. Key Concepts to Capture in your Documentation

2. Examples of Orthopedic Diagnoses and Procedures in ICD-10

3. Upcoming Sessions
Upcoming Webconferences

Through the ICD-10 Success Series, The Valley Hospital will have access to multiple Webconferences that cover a range of ICD-10 Documentation Topics. Please make time to attend topics pertinent to your practice!

**Upcoming Sessions:**

- November 19th – Diabetes
- December 3rd – Anemia
- December 10th – Cellulitis
- December 17th – Ambulatory

*Please reach out to John McConnell, mccojo@valleyhealth.com if you need assistance registering.*

*All sessions are from 12-1pm EST*
https://www.surveymonkey.com/s/ICD10-Orthopedics
Questions?

Please do not forget to fill out your CME Survey Link!
Appendix
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change</td>
<td>Taking out or off a device from a body part and putting back an identical or similar device in or on the same body part without cutting or puncturing the skin or a mucous membrane</td>
<td>Changing a drainage device to lower extremity</td>
</tr>
<tr>
<td>Detachment</td>
<td>Cutting off all or a portion of the upper or lower extremities</td>
<td>Below the knee amputation, disarticulation of shoulder</td>
</tr>
<tr>
<td>Excision</td>
<td>Cutting out of off, without replacement, a portion of a body part</td>
<td>Excisional debridement of wound</td>
</tr>
<tr>
<td>Fusion</td>
<td>Joining together portions of an articular body part rendering the articular body part immobile</td>
<td>Spinal fusion, ankle arthrodesis</td>
</tr>
<tr>
<td>Insertion</td>
<td>Putting in a nonbiological appliance that monitors, assists, performs or prevents a physiological function but does not physically take the place of a body part</td>
<td>Insertion of stimulator lead into muscle</td>
</tr>
<tr>
<td>Reattachment</td>
<td>Putting back in or on all or a portion of a separated body part to its normal location or other suitable location</td>
<td>Reattachment of hand</td>
</tr>
<tr>
<td>Release</td>
<td>Freeing a body part from an abnormal physician constraint by cutting or by use of force</td>
<td>Carpal tunnel release</td>
</tr>
</tbody>
</table>
### Root Definitions Continued

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Removal</strong></td>
<td>Taking out or off a device from a body part</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Cervical vertebral disc removal</td>
</tr>
<tr>
<td><strong>Repair</strong></td>
<td>Restoring, to the extent possible, a body part to its normal anatomic structure and function</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Suture of a body part</td>
</tr>
<tr>
<td><strong>Replacement</strong></td>
<td>Putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part</td>
</tr>
<tr>
<td></td>
<td>The biological material is nonliving or the biological material is living and from the same individual. The body part may have been previously taken out, previously replaced, or may be taken out concomitantly with the replacement procedure. If the body part has been previously replaced, a separate removal procedure is coded for taking out the device used in the previous replacement.</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Total hip replacement, bone graft, free skin graft</td>
</tr>
<tr>
<td><strong>Reposition</strong></td>
<td>Moving to its normal location or other suitable location all of a portion of a body part</td>
</tr>
<tr>
<td></td>
<td>The body part is moved to a new location from an abnormal location, or from a normal location where it is not functioning correctly. The body part may or may not be cut out or off to be moved to the new location</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Fracture reduction</td>
</tr>
</tbody>
</table>
## Root Definitions Continued

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resection</td>
<td>Cutting out or off, without replacement, all of a body part</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Resection of hip joint</td>
</tr>
<tr>
<td>Revision</td>
<td>Correcting, to the extent possible, a malfunctioning or displaced device</td>
</tr>
<tr>
<td></td>
<td>Revision can include correcting a malfunctioning device by taking out and/or putting in part of the device. Revision is coded only when the objective of the procedure is to correct the position or function of a previously placed device, without taking the entire device out and putting a whole new device in its place.</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Adjustment of hip replacement</td>
</tr>
<tr>
<td>Supplement</td>
<td>Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part</td>
</tr>
<tr>
<td></td>
<td><strong>Example:</strong> Put in a new acetabular liner in a previous hip replacement</td>
</tr>
</tbody>
</table>