

Socioeconomic tips of the month

Editor's note: Developed by the College's Socioeconomic Affairs Department and consultants, this column is accessible on our Web site (<http://www.facs.org>). If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Socioeconomic Affairs Department via telephone at 312/202-5150, via fax at 312/202-5021, or via e-mail at socioecon@facs.org.

Q. A plastic surgeon colleague recently told me that I am underreporting my excision and repairs. Please let me know what is the correct way to report excision and repairs.

A. An important meeting on this issue was held on May 1, 1997. The meeting was held prior to an AMA CPT Editorial Panel meeting, and interested specialties, along with HCFA representatives, were in attendance. The subject of the meeting was a proposal published in the November 22, 1996, *Federal Register* to redefine the definition of intermediate and complex repairs, and to propose a new way to bundle repairs into excision codes. The proposed changes were not adopted. However, decisions made at this May 1, 1997, meeting were not published in the *Federal Register*, but were written up in the Medicare Carrier Manual Instructions with a July 1, 1998, effective date. Simply, Medicare carriers were instructed that the existing CPT definitions for simple, intermediate, and complex repairs, as listed in the AMA's *Physicians' Current Procedural Terminology*, would be the accepted definitions.

At the same time, HCFA announced through Medicare Carrier Manual Instructions that payment for excisions of *small benign lesions*—defined as benign lesions with a diameter of 0.5 cm or less—includes payment for simple, intermediate, and complex repairs. Separate payment for simple, intermediate, and complex repairs (CPT codes 12001 through 12018 and 12031 through 13153) will not be made when reported with CPT codes 114000, 11420, and 11440 for the same lesion. Repair codes for separate lesions excised on the same date need to be reported with Modifier -59 to indicate that this repair is payable and separate from the excision

of the small benign lesion.

Medicare payment for medically necessary intermediate repairs (CPT codes 12031 through 12057) or complex repairs (CPT codes 13100 through 13153) may be made when reported with codes for excision of benign lesions greater than 0.5 cm (CPT codes 11401 through 11406, 11421 through 11426, 11441 through 11446), or with codes for excision of malignant lesions of any size (CPT codes 11600 through 11646).

The multiple surgery procedure rule applies, which means that Modifier -51 is appended to any lesser services provided on the same day.

We understand that a number of surgeons have been reporting only the intermediate or complex repair(s), or only the excision. If surgeons and their billing staff were following the November 22, 1996, proposed rule and were not aware of the manual revision, they are inappropriately underbilling their excisions and repairs at a significant loss of income to their practice. At the time of this proposed rule, a few third-party insurers revised their payment policies incorrectly. If you are aware of any such policies, please provide information to Diane Schneidman in the Chicago Office of the Socioeconomic Affairs Department via telephone at 312/202-5367 or via e-mail at dschneidman@facs.org.

Jacqueline Leopold, president of Practice Management Consulting Corp., the firm that conducts coding workshops for the College, recommends that you share this information with your billing staff or your medical billing company. In times of decreasing payments for services provided, it is more important than ever to develop a practice compliance plan and ensure that your staff and consultants are up-to-date on all coding and reimbursement issues.

Q. How do I report closure with Dermabond?

A. The question of how to code for the use of tissue adhesives is quite confusing now that the November 2, 1999, *Federal Register* has indicated that Medicare has designated a new HCPCS code, G0168, "Wound closure utilizing tissue adhesives only." This code is to be used when a
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Senior Chapter representatives will consult with the Fellow about the centres to be visited in Australia and New Zealand, the local arrangements for each center and other advice and recommendations about travel schedules. The Fellow is to make his/her own travel arrangements in the U.S., as this makes available to him/her reduced fares and travel packages for travel in Australia and New Zealand.

The Fellow will be selected after review and evaluation of the final applications by the American College of Surgeons' International Relations Committee. A personal interview may be requested prior to the final selection.

Applications for this travelling fellowship are to be requested from the Director, Fellowship Dept., American College of Surgeons, 633 N. Saint Clair St.,

Chicago, IL 60611-3211.

The closing date for receipt of completed applications is April 1, 2000.

The successful applicant and an alternate will be selected and notified in August 2000. The formal announcement of the recipient will be made during the 2000 Clinical Congress of the American College of Surgeons in Chicago, IL, October 22-27.

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wound is closed solely with the use of the new product, Dermabond. AMA CPT had addressed closure with tissue adhesives in a May 1999 *CPT Assistant* article, whereby it was noted that the definition of "simple repair" was being modified to include tissue adhesives. The description introducing the Repair (Closure) section of CPT 2000 states: "Use the codes in this section to designate wound closure utilizing sutures, staples, or tissue adhesives (for example, 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips."

CPT previously taught that the unlisted code, 17999, should be reported for wound closure with tissue adhesives. The May 1999 *CPT Assistant* further noted: "It is important to note that when intermediate or complex repair is performed with tissue adhesive closure of the skin

(epidermal and dermal) layer, the intermediate or complex repair code would be reported, as appropriate, without separately reporting the adhesive closure of the skin layer." The article also mentions that there is a separate code, CPT 65286, for repair with tissue glue for wounds of the cornea and/or sclera, and this would be appropriate to use. The noted changes to CPT 2000 that reflect use of the repair closure codes for tissue adhesives are now contrary to HCFA's HCPCS code G0168 for use of tissue adhesives only. HCFA's new code will apply to Medicare claims and the reimbursement level will be only about half that for the simple repair codes. Effective January 1, 2000, surgeons and their billing staff will need to be sure they meet the coding rules of each respective third-party payor when they report the use of tissue adhesives. □

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