

# Socioeconomic tips

---

## ACS Coding Hotline: Unusual questions

by the Division of Advocacy and Health Policy

This column lists some questions recently posed to the ACS Coding Hotline and the responses. As a benefit of membership in the College, ACS Fellows and their staff may consult the hotline 10 times annually without charge. If your office has coding questions, please contact the Coding Hotline at 800/227-7911 between 7:00 am and 5:00 pm Mountain Time, holidays excluded.

### **How do I code when the physician is performing a percutaneous common iliac vein balloon angioplasty, placement of a 14 mm x 50 mm wall stent, another balloon angioplasty of the same area, and a follow-up angiogram to make sure the patient has good flow in the common iliac vein?**

The following procedure codes would be used to reflect the procedures performed: Code 37205, *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel*, and code 75960-26, *Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel*. The code for placement of the stent includes the preplacement and postplacement angioplasties. The modifier -26, *Professional Component*, is appended to the radiology code since the physician is supervising and interpreting the images as well as dictating a report of his or her findings but does not own the equipment.

### **What code do you suggest using when the physician is taking down one part of a previous anastomosis? The physician is taking down or disconnecting the stomach and common bile duct anastomosis, reconnecting or anastomosing the common bile duct to a different part of the**

## Around the corner

### January

The following will be implemented January 1:

- The 2007 Medicare fee schedule
- The 2007 CPT codes
- The Medicare national Correct Coding Initiative (NCCI), version 13.0
- The Medicare Medically Unlikely Edits (MUE), version 1.0. A description of these edits will appear here in a future issue of the *Bulletin*.

### February

Economedix will hold two teleconferences this month. The first, on February 14, is "Medicare Update for 2007." The second, on February 28, is "Advanced CPT Coding." For more information and to register, go to <http://yourmedpractice.com/ACS/>.

**Reminder:** The NPI numbers are required on Medicare claims submitted on or after May 23, 2007. If you have not submitted an application for your NPI, you need to do so immediately.

### **stomach, and then suturing the old connection site of the stomach.**

Use the procedure code 47760, *Anastomosis of extrahepatic biliary ducts and gastrointestinal tract*, with a modifier -22, *Unusual Procedural Services*. The modifier -22 covers the additional work of closing the old anastomosis. Increase the fee appropriately and send the

---

hard copy of the operative note and a cover sheet to explain the extra work and the use of the modifier -22.

**How do I code a gastrojejunostomy Roux-en-Y when the physician does an anastomosis of the stomach to the jejunum and an anastomosis of the jejunum to the jejunum for duodenum exclusion? No stomach was resected.**

The appropriate procedure codes to use are code 43820-51, *Gastrojejunostomy; without vagotomy* and code 44130-51, *Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)*. These codes cover both the anastomosis sites and complete the Roux-en-Y.

**The patient's diagnosis is adenocarcinoma of the fourth portion of the duodenum with right lobe liver metastasis. The procedure performed was resection of right lobe lesion of liver, resection of the fourth portion of the duodenum with primary duodenojejunostomy, and resection of ischemic ileotransverse colostomy with creation of new ileotransverse colostomy. A Moss gastrojejunostomy tube was inserted and advanced through the pylorus and placed into the duodenum.**

The following procedure codes should be used: Code 47120, *Hepatectomy, resection of liver; partial lobectomy*; code 44160-59-51, *Colectomy, partial, with removal of terminal ileum with ileocolostomy*; code 44120-51, *Enterectomy, resection of small intestine; single resection and anastomosis*; and code 43830-22, *Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)*. The modifier -22 is for placement of the gastrojejunostomy tube into the duodenum. Increase the fee for modifier -22 and send the hard copy of the operative note and a cover note to explain the extra work and the use of the modifier -22.

**A thoracic surgeon and a vascular sur-**

**geon operated on a patient with a pancreatic tumor with perivascular invasion. Do they need to code the excision of the pancreatic tumor with modifier -62, *Two Surgeons*? The thoracic surgeon excised the tumor and then asked the vascular surgeon to ligate the vessels that were surrounding the tumor.**

The correct code for both surgeons to report is code 32503, *Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s)*, which includes all of the vascular work.

There are two modifiers that can be used: Modifier -62, *Two Surgeons*, or modifier -80, *Assistant Surgeon*. (Modifier -82, *Assistant Surgeon [when qualified resident surgeon not available]* is used in teaching institutions in place of modifier -80.) Which modifier you use depends on whether the two surgeons have agreed they will report modifier -62; if so, both should have prepared operative reports on their respective portions of the operation. If the vascular surgeon did not prepare a separate operative report, he should report code 32503 with the appropriate assistant surgeon modifier.

**When 12 out of 20 lymph axillary lymph nodes are excised, would this be coded as code 38740, "superficial," or as 38745, "complete"?**

If the procedure code 38740, *Axillary lymphadenectomy; superficial* is chosen, use modifier -22, *Unusual Procedural Services*; if coded as 38745, *Axillary lymphadenectomy; complete*, use modifier -52, *Reduced Services*. The fee will increase or decrease depending on which modifier is used. A copy of the operative note and a cover note explaining the additional work involved will be required if modifier -22 is used. Documentation may also be required if modifier -52 is used.

**The physician performs a hemicolectomy and a resection of the small bowel. Would**

---

**this be reported as code 44160 or small and large bowel resections?**

If two resections were done and two separate anastomoses were completed, then the code 44120–51, *Enterectomy, resection of small intestine; single resection and anastomosis*, and code 44140–51, *Colectomy, partial; with anastomosis*, would be correct. If one resection and one anastomosis is performed, use code 44160, *Colectomy, partial, with removal of terminal ileum with ileocolostomy*.

**I need codes for aortic and bi-iliac artery stent placement for exclusion repair of common iliac artery aneurysm. I also need the code for coil embolization of the hypogastric artery. This was done 10 times. Can it be reported multiple times?**

Use code 34812–50, *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral*, for the bi-iliac exposure and use code 34825–50, *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel*, for placement of stents. Use code 34802, *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis using modular bifurcated prosthesis (one docking limb)*, to report the aortic repair. The code for coil embolization is code 37204, *Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck*. This is reported once for every vessel field. If it is reported more than once, append modifier –59, *Distinct Procedural Service*.

**What code should I use for closure of an anal fissure in the subcutaneous tissue when the physician is using an anal plug?**

Use code 46270, *Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutane-*

*ous*. The term “surgical treatment” is non-specific enough to use for placing the anal plug into the fissure site. Q