Socioeconomic tips

Frequently asked ACS Coding Hotline questions

by the Division of Advocacy and Health Policy

This column lists some questions recently posed to the ACS Coding Hotline and their responses. Fellows and their office may consult the hotline 10 times annually without charge as a benefit of membership in the College.

Coding the excision of a benign or malignant skin lesion requires measuring the lesion. How is the size of the lesion properly measured?

First of all, the lesion must be measured before excision. The measurement is the greatest clinical diameter of the lesion plus the margin required for the excision. Measurements of three skin lesions are illustrated on page 51 of the professional edition of *Current Procedural Terminology (CPT)* for 2005.

I am uncertain whether to use the –58 modifier, *Staged or related procedure or service by the same physician during the postoperative period*, or the –78 modifier, *Return to the operating room for a related procedure during the postoperative period*. Can you help me?

In general, use the –58 modifier when the second procedure was planned at the time of the first procedure. In fact, it is very useful to indicate on the operative report for the first procedure that a second procedure will take place. The –78 modifier generally is used when an emergency arises during the postoperative period that requires returning to the operating room. For Medicare and some other payors, both modifiers are used to reset the global period.

What code should be used for wound exploration and evacuation of a hematoma following a mastectomy?

The correct code is 35820, *Exploration for postoperative hemorrhage, thrombosis or infection; chest.* Modifier –78, *Return to the operating room for a related procedure during the postoperative period*, should be appended to ensure that the claim is accepted. Appending the modifier will also reset the start of the global period to the date of the second procedure. Note that codes 35800-35860 are for postoperative exploration of the neck, abdomen, and extremities, in addition to the chest, so the series of codes may be used in many situations.

I billed Medicare for codes 44005, *Enterolysis (freeing of intestinal adhesions) (separate procedure)*; 43830, *Gastrostomy, open; without construction of gastric tube (eg. Stamm procedure) (separate procedure)*; and 44015, *Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure.)* I was only paid for code 43839, the g-tube. Is that correct, or should I appeal?

The payment was correct. Two of the procedures are designated "separate procedure," meaning that the codes cannot be billed with any other code of which it is considered an integral component. Code 44015, the g-tube, has a plus sign in front of it, meaning it is an add-on code. However, it may not be reported with code 43830. The correct coding initiative (CCI) bars payment for codes 44005 and 44015 when reported with code 43830.

Are codes 61210, *Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s) or pressure recording device (separate procedure)*, and 61312, *Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural*, considered bundled?

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The CCI edits generally consider these two codes to be bundled. However, if code 61210 is performed for a separate purpose, it is possible to append a –59 modifier, *distinct procedural service*, and bill for both. In this case, 61210 was probably performed to place a pressure recording device and a hematoma was evacuated in a separate procedure.

My physician performed a consultation in the emergency room and later that day admitted the patient to the hospital. What code should I use to report the admission?

In CPT, the introductory notes to the initial hospital care codes state that all of the evaluation and management (E&M) services performed on the same date as a hospital admission are considered part of the initial hospital admission. Therefore, the code selected for the hospital admission should reflect all of the E&M care given in such places as the office, skilled nursing facility, and emergency room, as well as the initial hospital setting. Incidentally, the same rule applies to a skilled nursing facility admission.

How do I code for the removal of a g-tube in the office? Another physician placed it.

Removal of a g-tube in the office is always reported using an E&M code.

My doctor saw a patient in consultation for a positive mammogram and performed an open breast biopsy. Because the pathological report came back positive for cancer, we called the patient back within the 10-day global period of the breast biopsy to discuss the treatment options, including more surgery. How do I code for each of these encounters?

The secret is careful use of ICD-9-CM diagnosis code(s) and CPT modifiers. When you perform the consultation and the open breast biopsy, you only know that the patient has an unspecified breast mass, ICD-9-CM code L11.72, so that is the diagnostic code to report with the claims for both the consultation and the breast biopsy. Once the pathology report is in hand, though, you know that the patient has a diagnosis of cancer. When you call the patient back in the global period of the open breast biopsy for an E&M service to counsel on breast cancer, report the appropriate level of an established patient E&M service with a –24 modifier, *Unrelated evaluation and management service by the same physician during a postoperative period,* and report the diagnosis code of breast cancer. Also report the subsequent surgery using the diagnosis code of breast cancer. If it is performed within the global period of the breast biopsy, append a modifier –58, *Staged or related procedure or service during the postoperative period*. The description of modifier –58 indicates that it is appropriate to use it for therapy following a diagnostic surgical procedure.

I know that when we do a mastectomy for treatment, we use the ICD-9-CM code for cancer in the appropriate part of the breast. What diagnostic code should be used for a prophylactic mastectomy?

In this case, use a code from the V section of ICD-9-CM. Code V50.41 is the correct one to use. Ω