

# Socioeconomic tips of the month

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## Answers to common hotline questions

This month's column focuses on various coding scenarios that are frequently the subject of inquiries from surgical practices that call the College's coding hotline.

### **Removal of G-tubes**

The CPT manual does not contain a code that accurately describes removal of a G-tube. When a G-tube is removed in the operating room, the unlisted code 43999 should be reported. Also, because an unlisted code is being reported, the claim should be submitted on paper and be accompanied by a copy of the operative report describing the service performed. If the G-tube is removed in the office or at the bedside in the hospital, the service is considered part of any evaluation and management service that is provided.

### **Codes 11040-11044 versus 97601-97602**

Codes 97601 and 97602 were added to CPT to describe active wound care management performed by nonphysician professionals acting within the scope of their licenses. These codes should be reported when physicians assistants, nurse practitioners, wound care nurses, physical therapists, and so on perform either selective or nonselective debridement on wounds.

CPT codes 11040-11044 describe surgical debridement performed by surgeons. These codes should be reported (rather than 97601 and 97602) when a surgeon performs an excisional debridement.

If, for example, a patient presents with necrotic tissue on the left thigh and the physician debrides the area from the skin to the subcutaneous tissue, code 11042—Debridement; skin, and subcutaneous tissue—would be reported. As the guidelines indicate in the CPT book, it is inappropriate to report codes 11040-11044 in addition to codes 97601 or 97602.

### **Colonoscopy for colonic tattooing**


Following a separate encounter in which the physician removed a polyp, the patient returns

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for colonic tattooing—that is, injection of dye through a sclerosing needle into the stalk of the previously removed polyp. In this situation, the unlisted code 45999 would be reported. If, however, the physician performs a colonoscopy with or without collection of specimen(s) by brushing or washing, with or without colon decompression and colonic tattooing, then the diagnostic colonoscopy code 45378 would be reported. If the physician believes there was increased work involved due to the colonic tattooing, modifier -22 may be appended to code 45378. When appending modifier -22, however, a note should be included that describes the increased work.

### **Laparoscopic umbilical hernia repair**

CPT does contain some hernia repair codes performed by laparoscopy; however, these codes are for initial and recurrent inguinal hernia repairs. CPT does not contain a specific code that describes laparoscopic umbilical hernia repair. Therefore, the unlisted laparoscopy code 49659 should be reported for this service. It is important to remember that it is inappropriate to report a code that describes an open repair when the service was performed laparoscopically.

Again, when reporting an unlisted code such as 49659, the claim should be submitted on paper and a copy of the operative report describing the service performed should be included. 

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This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Health Policy and Advocacy Department by fax at 202/337-4271, or e-mail Health Policy Advocacy@facs.org.