

Socioeconomic tips of the month

Answers to common hotline questions

Q. What code should we use when our surgeon performs an excision of tumors in the abdomen?

A. You should report either code 49200, Excision or destruction by any method of intraabdominal or retroperitoneal tumors or cysts or endometriomas, or code 49201 if the procedure was extensive.

Q. When performing destruction of lesions on the anus, is it appropriate to report code 46924 for each lesion taken?

A. Code 46924, Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle; extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery) includes the destruction of one or more lesions. You're allowed to report the service only once.

Q. Which ICD-9-CM code would I use to report the reversal of a vasectomy?

A. You should use code V26.0, Tuboplasty or vasteroplasty after previous sterilization.

Q. How do I report the excision of a subcutaneous lipoma from the thigh?

A. You should report code 27327, Excision, tumor, thigh or knee area, subcutaneous.

Q. How do I code for the surgical take-down of a tracheostomy?

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Around the corner

September

- Postgraduate course on coding, compliance, and reimbursement presented by the ACS during the Society of Laparoendoscopic Surgeons' Eleventh International Congress and ENDO EXPO on September 11, 2002, in New York, NY. Contact Flor Tilden at 305/665-9959 for registration form.

- ACS-sponsored practice management course for surgeons on September 21, 2002, in Miami, FL. Visit the ACS Web site at <http://www.facs.org/dept/hpa/index.html> to register.

A. "Take-down" has several meanings. In general, it does not imply a repair was performed. If the "take-down" is for the purpose of repair or closure of a tracheostomy site or wound, you should refer to codes 31750-31899 and select the code that most appropriately describes the procedure performed. If the "take-down" was performed in preparation for some other procedure, such as a thyroidectomy, you should append modifier -22 to the appropriate thyroidectomy code (codes 60240-60271) and submit a copy of the operative report with the claim. If the "take-down" is performed at the time of a laryngectomy, it would be considered an inherent part of the laryngectomy, and you would not report the service separately.

Q. How do you code for a brachial-to-brachial artery bypass in the arm?

A. If the brachial-brachial bypass is done for trauma, either code 35236 or 35266 should be reported, depending on whether a vein
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tional Institute of Allergy and Infectious Diseases, at the National Institutes of Health. He returned to Massachusetts General Hospital in 1973, and completed his residency in 1975. From 1976 to 1978, Dr. Harrison was a pediatric surgery fellow, first at the Rikshospitalet in Oslo, Norway, and then at the Children's Hospital of Los Angeles (CA).

Dr. Harrison has spent most of his career at the University of California, San Francisco. He has been an assistant professor of surgery (1978-1982); associate professor of surgery and pediatrics (1982-1988); and professor of surgery and pediatrics (1988-1991). Dr. Harrison continues his work at the University of California, San Francisco, and is currently chief, division of pediatric surgery (1988-present); director, Fetal Treatment Center (1981-present); and professor of surgery, of pediatrics, and of obstetrics, gynecology, and reproductive sciences (1991-present). In addition, Dr. Harrison served as surgeon-in-chief for Lucile Packard Children's Health Services from 1997 to 1999.

Throughout his career, Dr. Harrison has remained active in clinical practice and is a member of many prominent organizations in the surgical profession, including being a founder and president of the International Fetal Medicine and Surgery Society, and serving as chair of the American Pediatric Surgical Association's Committee on Fetal Therapy. He has served on the editorial boards of the *Journal of Pediatric Surgery* and *Fetal Therapy and Diagnosis*.

In addition, Dr. Harrison is committed to disseminating knowledge about his work in fetal surgery. One of his first publications in 1980 reported a fetal surgery model in the lamb for congenital diaphragmatic hernia. He subsequently has published more than 400 papers on a multitude of fetal surgery topics, and has served as a lecturer for numerous surgical and medical societies around the world. In 1984, he published the first comprehensive textbook on fetal therapy, *The Unborn Patient: Prenatal Diagnosis and Treatment*, which is now in its third edition.

Dr. Harrison's work in fetal surgery began immediately after his residency was completed. During the 1980s and 1990s, he created and practiced the techniques that have made fetal surgery the major contribution it is within the surgical profession. His efforts took him from laboratory to clinical trials and were furthered by the development of laparoscopy, which led to his groundbreaking work in creating the techniques for fetoscopic surgery that he calls fetendo—it has become the basis for minimally invasive fetal surgery worldwide. Dr. Harrison's work has made an impact on the performance of surgery to treat the smallest patients through a wide range of techniques.

The Jacobson Innovation Award is administered by the Honors Committee of the American College of Surgeons. Original thought combined with the first presentation of work that has led to a milestone in the advancement of surgical care is the main criterion for choosing a recipient of the Jacobson Innovation Award.

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graft or a synthetic graft was used as the bypass conduit. If the procedure is performed for an aneurysm, look at codes 35011, 35013, or 35045, which describe aneurysm repairs of the upper extremity, and select the appropriate code. If the bypass is performed for a reason other than trauma or aneurysm, you should report code 37799, Unlisted procedure, vascular surgery.

Q. How do you code for the passing of the dilator into the esophagus with no visualization for stricture without an EGD?

A. You should report code 43450, Dilation of esophagus, by unguided sound or bougie, single or multiple passes.

Q. How do I know if I should use the benign or malignant code when reporting the removal of a skin lesion?

A. When reporting the removal of skin lesions, you should wait until the pathology report comes back and code according to the results in the report. 