Socioeconomic tips of the month

Q. How do we code "debridement of abdominal wall fascitis?"

A. Use CPT codes 11040-11044, depending on the depth of the debridement. Surgeons also may consider CPT code 22999, unlisted procedure, abdomen, musculoskeletal system, and include a copy of the operative report. Codes pertaining to debridement of skin, subcutaneous tissue muscle, and bone (CPT codes 16010-16030) are categorized in two ways: by the use of anesthesia and by assessment of the size of the burn wound as "small," "medium," or "large." While these terms are not specifically defined in CPT and are subject to the physician's clinical judgment, examples of "medium" (whole face or whole extremity) and "large" (more than one extremity) are given in codes 16025 and 16030. While there are no examples of "small," by inference, these would be smaller than the entire face or extremity.

Q. We need some help understanding when to use modifier -78 and when to use modifier -79.

A. Use modifier -79 to report a procedure or service performed during the postoperative (global) period of a totally unrelated procedure or service by the same physician. To help identify the second service as being unrelated, there will usually be a different diagnosis code. For example, the patient had a cholecystectomy performed; two months later the patient developed acute appendicitis. The same physician treating both conditions would report the appendectomy code with a -79 modifier *and* the diagnosis of appendicitis.

The -78 modifier is used to report a service that requires a return trip to the operating room for a related condition during the postoperative period. For example, the patient in the previous example has the cholecystectomy, then three days later has a reopening of the surgical incision and the repair of a bleeding vessel, performed in the operating room by the same surgeon. Modifier -78 would be appended to the procedure code of the second procedure performed.

Q. Can we bill for the assistant at surgery when using a physician assistant? And at what percent?

A. You may bill the services of the physician assistant if the individual is a member/employee of your group practice and will not be billing independently under his or her own provider number. You will report the same procedure codes as used to report the surgeon's service, and append modifier -AS (Physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) services for assistant at surgery) for Medicare; for private insurers use modifier -81 (Minimum assistant surgeon). Medicare allows 16 percent for a physician who assists a primary surgeon. Medicare allows 85 percent of the 16 percent for a nonphysician (PA, NP, or CNS) who assists the primary surgeon. *A physician assistant will be allowed to assist a primary surgeon only on those procedures identified as allowing an assistant surgeon, and only in lieu of the assistant physician surgeon.* Refer to the College's 1999 Study on Physicians as Assistants at Surgery that specifies those procedures that "almost always," "sometimes," or "almost never" require an assistant surgeon, available on the College's Web site at *http://www.facs.org/about_college/acsdept/hpa_dept/hpa_pubs/pubs.html.*

Q. We did an operation on a patient, and then we needed to readmit the patient for a wound abscess. Can we charge for the readmission and daily care?

A. If the readmission is within the global period of the original surgery and is for the same problem as the original surgery, you cannot charge for the readmission or hospital visits. If the patient's condition and the treatment of the abscess *requires* a trip to the operating room, you may bill the procedure performed and append modifier -78 (Return to the operating room for a related procedure during the postoperative period). If the patient is readmitted after the global period of the original surgery expires, the hospital admission and subsequent care may be billed with the appropriate level of service reported.

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lymphoscintigraphy to 90%, compared with 50% using IP injections. Preoperative SA lymphoscintigraphy resulted in the rapid visualization of axillary sentinel nodes within 30 min of SA injection, enabling a visual determination of the approximate number of sentinel nodes and their relative location within the axilla. We conclude SA injection of unfiltered Tc-99m-SC is superior to IP injections when performing preoperative breast lymphoscintigraphy, and is a visually useful aid to lymphatic mapping for breast cancer.

New slide sets available

The Advisory Council for General Surgery, with assistance of Jeffrey H. Peters, MD, FACS, is offering two new slide sets on gastroesophageal reflux disease. The first set consists of 50 slides with a script, for use by surgeons when lecturing to general audiences such as primary-care physicians (price: $35). The second set includes all of the 50 slides in the first set and an additional 18 slides (price: $40). This more comprehensive presentation is meant for surgical audiences.

These new slide sets are up-to-date, with numerous citations to the critical literature and excellent graphic displays. Both sets are available as 35mm slides or on a CD-ROM for use as a PowerPoint presentation.

The popular slide set, "The Acute Abdomen Curriculum," is now also available on a CD-ROM for a PowerPoint presentation.

To order the slide sets, visit *http://www.facs.org/about_college/acsdept/edsurg_dept/gsre_src.html.* If you have questions about the slide sets, contact Jan Fair, ACS Surgical Education and Research Dept., tel. 312/202-5354.

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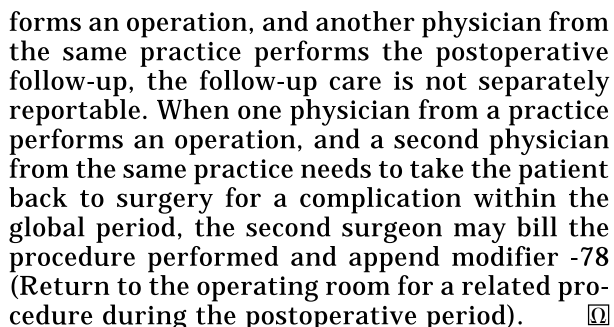
Q. When performing a cholecystectomy, cholangiogram, and placement of a T-tube, do we code for the T-tube placement?

A. There is no separate code for placement of a T-tube. CPT Code 47610 is cholecystectomy with exploration of common duct. Inherent in this procedure is performance of a cholangiogram and placement of a T-tube or other biliary drainage tube. The T-tube insertion is included in the major procedure; do not code separately.

Q. We have a merged practice. Within the same practice, can we bill for seeing the same patient?

A. Two physicians within a practice are treated as one when caring for a patient. When one physician from a practice performs an operation, and another physician from the same practice performs the postoperative follow-up, the follow-up care is not separately reportable. When one physician from a practice performs an operation, and a second physician from the same practice needs to take the patient back to surgery for a complication within the global period, the second surgeon may bill the procedure performed and append modifier -78 (Return to the operating room for a related procedure during the postoperative period). Ω



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 Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail HealthPolicyAdvocacy@facs.org.

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