

# Socioeconomic tips of the month

## Responses to common coding questions

by the Division of Advocacy and Health Policy

This column addresses questions from Fellows 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 you would like to see other topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or via e-mail at [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).

### Coding hotline questions

One of the benefits that the ACS provides to Fellows is access to a coding hotline (800/ACS-7911). ACS Fellows are entitled to 10 consultation units (CUs) per 12-month period. Practices that have coding questions may contact the hotline between 8:00 am and 6:00 pm, CST, holidays excluded. Here are the answers to some frequently asked questions.

**Q.** How do we code for a laparoscopic incisional hernia repair with mesh? Is it appropriate to use code 49568 in addition to code 49659?

**A.** You would not use code 49568, Implantation of mesh or other prosthesis for incisional or ventral hernia repair (list separately in addition to code for the incisional or ventral hernia repair). It is only appropriate to report the use of mesh when an open incisional hernia repair is performed. When the procedure is performed laparoscopically, report code 49659, Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy, and include the value of the extra work of the mesh. Of course, the expense of the mesh itself is borne by the facility.

**Q.** We submitted a claim for a procedure using the -22 modifier and the modifier was not allowed. What can we do?

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### Around the corner

#### November

- The 90-day implementation period during which Medicare will allow claims to be submitted with the 2002 and 2003 versions of ICD-9-CM diagnosis codes continues until December 31. After that, only the 2003 version will be accepted.
- 2003 Medicare fee schedule scheduled for release. Medicare carriers distribute fee schedules to providers.
- CPT 2003 available.

**A.** The -22 modifier is used to indicate that a procedure was a complex or an unusual operative case. Due to misuse of modifier -22, many payors are denying it. Medicare "carriers continue to have authority to increase payment for unusual circumstances (-22) or decrease payment for reduced services (-52), based on review of medical records and other documentation. Modifier -22 may be reported with all surgical procedures, including assistant-at-surgery services, regardless of the duration of the global period. Documentation of the unusual circumstances must accompany the claim (for example, a copy of the operative report and a separate statement written by the physician explaining the unusual amount of work required)."<sup>\*</sup> Keep in mind that many payors will not pay extra for anything less than 150 percent of the work of the regular procedure.

**Q.** Our doctor performed a procedure, and the charge sheets indicate that he did control of bleeding. How do we code for that procedure?

<sup>\*</sup>American Medical Association: *Medicare RBRVS: The Physicians' Guide*. Chicago, IL: American Medical Association, 2000, p. 83-84.

**A.** When a major procedure is performed, control of bleeding is included in the procedure. If the major procedure performed was control of bleeding, identify the site and method used and then code accordingly. Some codes that may be appropriate are the 35201 series, Repair blood vessel other than for fistula, with or without patch angioplasty, or the 37565 series, Ligation and other procedures.

**Q.** How do we code for the insertion of a temporary pacemaker?

**A.** Use code 33210, Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure).

**Q.** How do we code for the closure of a colostomy?

**A.** Report code 44620, Closure of enterostomy, large or small intestine.

**Q.** How do we code for the repositioning of a jejunostomy tube through the duodenum?

**A.** Report code 43761, Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition.

**Q.** How do we code for the oversewing of an ulcer?

**A.** Report code 43840, Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury.

**Q.** How do we code for a laparoscopic liver biopsy?

**A.** Report code 47379, Unlisted laparoscopic procedure, liver.

**Q.** What ICD-9-CM diagnosis code would we use for a mastectomy on a male patient?

**A.** Depending on the site, report either ICD-9-CM diagnosis code 175.0, Malignant neoplasm of nipple and areola of male breast, or code 175.9, Malignant neoplasm of other and unspecified sites of male breast.

**Q.** What code would we use when a skin-sparing mastectomy is performed?

**A.** You would report code 19182, Mastectomy, subcutaneous. If the nipple and areola complex is removed, you would report either code 19180, Mastectomy, simple, complete; or code 19240, Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle modified radical mastectomy. The specific code would depend upon the actual procedure performed.

**Q.** How do we code for a scar revision on a mastectomy site?

**A.** Use the appropriate CPT complex repair code (code 13100 through 13102, Repair complex, trunk...). The CPT introductory remarks regarding repairs specifically mention scar revisions and state that a complex repair requires more than layered closure. Choose the code based on the size of the repaired wound, which should be measured and recorded in centimeters, whether it is curved, angular, or stellate.

**Q.** How do we code for a thrombin injection for a pseudoaneurysm of an extremity?

**A.** Report code 36002, Injection procedures (such as thrombin) for percutaneous treatment of extremity pseudoaneurysm. 