Socioeconomic tips of the month

Common coding hotline questions

by the Division of Advocacy and Health Policy

One of the many 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) in one 12-month period. If your office has coding questions, please contact the hotline between 8:00 am and 6:00 pm central standard time, holidays excluded. The following are frequently asked questions that may provide some insight for your practice.

Q. How do I code when a physician's assistant, nurse practitioner, or surgical technician is assisting at surgery?

A. Medicare's guidelines state that physician's assistants (PAs), nurse practitioners (NPs), and certified clinical nurse specialists (CNSs) must have their own provider identification number (PIN) in order for a surgeon to report their services as assistants-at-surgery. In coding for their services, append health care common procedure coding system (HCPCS) modifier –AS to the Current Procedural Terminology (CPT) code used to report the procedure. Medicare does not recognize surgical technicians as providers and, therefore, CPT codes cannot be used to report their services. If the payor is a private insurer, check with the insurer to determine how the service should be reported.

Q. Our surgeon performed the PEG portion of an EGD during the same session that the gastroenterologist performed the EGD. I have looked at code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube*, code 43235, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure),* and code 43750, *Percutaneous placement of gastrostomy tube.* Should each physician report their own service with the gastroenterologist reporting code 43235 and the surgeon reporting code 43750, or do they both report 43246 with modifier –62?

A. Either option would be acceptable. If the surgeons want to report the same code, they should report code 43246 and append modifier –62. Each physician should dictate a separate note describing his/her portion of the service.

Q. How do I code when the physician did a colonoscopy with tattooing?

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, 2003. After that only the 2004 version will be accepted.
- CPT 2004 available.
- Economedix teleconferences scheduled as follows: Diagnosis Coding for Surgeons...ICD-9 (Oct. 29 and Nov. 1); Building Employee Superstars: Evaluations and Appraisals (Nov. 5 and 8); and Creating a Strategic Business/Marketing Plan for 2004 (Nov. 12 and15). For more information and to register, got to *http://yourmedpractice.com/ACS-Teleconference.*

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A. Report code 45381, *Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance).* This code is new in CPT for 2003

Q. We billed code 36870, *Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis),* to Medicare, and it was reduced because of the place of service (POS). Why?

A. The Medicare fee schedule contains both a facility and a nonfacility RVU for code 36870. The facility relative value unit (RVU) for this code is 7.78; the nonfacility RVU is 47.71. If the fee reported was based on the nonfacility RVU and the service was performed in a facility, this would be the reason for the reduction in reimbursement. When a procedure is performed in a facility, the physician is reimbursed solely for the work involved in the service because the other costs involved in providing the procedure (operating room, equipment, staff, and so on) are borne by the facility and separately reimbursed to the facility. It is important to remember to include the POS code on the submitted claim. You can find a list of current Medicare POS codes at *http://www.cms.gov/states/posdata.pdf.*

Q. If there is not a code for a laparoscopic procedure, how should it be coded? Do we report a diagnostic laparoscopic code and the open code?

A. If there is no specific code for the laparoscopic procedure, look for the appropriate unlisted laparoscopic code for the body site. If no laparoscopic code is listed for the body site, use the unlisted open code. Do not report both the laparoscopic and open code for the service. For example, for a ventral hernia repaired laparoscopically, report code 49659, *Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy*. Set the fee based on a reference code that describes a similar amount of physician work. Include a cover letter explaining why the fee was set based on that reference code and the operative notes.

Q. How do I code for a secondary closure of abdominal wall dehiscence with fibrin glue?

A. Either code 12020, *Treatment of superficial wound dehiscence; simple closure,* or code 13160, *Secondary closure of surgical wound or dehiscence, extensive or complicated,* would be acceptable, depending upon complexity and size.

Q. If the physician saw a patient two years ago and the patient is coming back to the office now for a different diagnosis, is it appropriate to code a new patient E/M encounter?

A. New patient status is not diagnosis-driven. CPT defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." Because the surgeon saw the patient two years ago, established patient codes should be used regardless of the diagnosis. Also consider whether the encounter meets the criteria for a consultation (an opinion requested, the request documented, a written report made and placed in the common medical record or sent to the requesting physician). If this is the case, then the appropriate consultation codes should be used, regardless of whether the patient is new or established.

Q. What code should be used when the patient already had a mastectomy due to breast cancer and now is having a recurrent cancer removed from the chest wall? Remember the patient no longer has a breast so this is from the muscle of the chest wall.

A. You can use code 21556, *Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular.*

Q. What codes should be used when the physician is called into the nursing home for a consultation?

A. The CPT definition of an Initial Inpatient Consultation states, "The following codes are used to report physician consultation provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting." Report the appropriate level of service in the code series 99251-99255.

Q. What code is used when the surgeon changes antibiotic beads in a wound?

A. *CPT Changes 2002* states: "Three new codes were added to describe insertion/removal/removal with reinsertion of a nonbiodegradable drug delivery implant. You will note the type of drug is not listed in the descriptors of codes 11981-11983, as various types of medications (such as hormones and antibiotic) for various indications can be administered using this type of implant." Code 11983, *Removal with reinsertion, nonbiodegradable drug delivery implant,* can be reported.

Q. Which codes may be used to bill for placement of BIOBRANE?

A. BIOBRANE, a brand name product for temporary skin substitute, consists of a custom-knitted nylon fabric mechanically bonded to an ultra-thin silicon membrane. It is used as a temporary skin substitute for the management of excised burn wounds and is applied to cover a meshed autograft for the purpose of diminishing healing and closing time of the mesh and improving graft take. Because BIOBRANE is used over the autograft, it would be considered a part of the dressing. You would report the appropriate autograft code found in the free skin graft series 15050-15261.

Q. How do I code for resection of the cecum?

A. Because the cecum is considered apart of the colon, use code 44140, *Colectomy, partial; with anastomosis.*

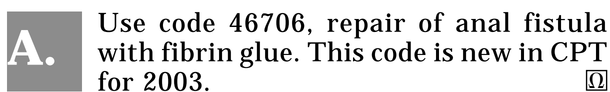
Q. How do we code for an excision of a skin lesion of the stoma site?

A. Report the appropriate code in either series 11400-11406, *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs;...*or series 11600-11606, *Excision, malignant lesion including margins, trunk, arms, or legs,* based on the pathology report.

Correction

A typographical error appeared in the April 2003 issue of this column that resulted in incorrect coding advice. The question and answer should have read:

Q. How do we code when the physician uses fibrin glue to repair an anal fistula?



A. Use code 46706, repair of anal fistula with fibrin glue. This code is new in CPT for 2003. 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. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or by e-mail at HealthPolicy Advocacy@facs.org.