

# Socioeconomic tips

## ACS Coding Hotline: Frequently asked questions

by the Division of Advocacy and Health Policy

This column lists some questions recently posed to the ACS Coding Hotline and the responses. Fellows and their office staff may consult the hotline 10 times annually without charge as a benefit of membership in the College.

### **The surgeon intended to do a screening colonoscopy, but he discovered some polyps, which he removed. How is the procedure reported?**

The rules for such a situation are as follows:

- Always code based on what actually happens, not what was planned.
- Any surgery including “surgical endoscopy” includes a diagnostic “look around” to identify anything unknown and abnormal, so the surgeon is working with as much information about the patient as possible.

When an endoscopy is performed, generally all of the organ is examined. Of course, if a proctosigmoidoscopy or sigmoidoscopy is performed, only a part of the colon is examined.

The surgeon would report Current Procedural Terminology (CPT)\* code 45384, *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*, or code 45385, *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*. The screening colonoscopy would not be reported. (Note that there is also a code to use when ablating tumors, polyps, or other lesions: code 45383, *Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*.)

\*All specific references to CPT terminology and phraseology are:  
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### **Around the corner**

#### **October**

- Medicare will implement the Correct Coding Initiative version 11.3 on October 1.
- Medicare requires updated ICD-9-CM diagnosis codes on October 1. ICD-9-CM is available by purchase from the American Medical Association and other vendors. The updates are also available at [www.cms.hhs.gov/medlearn/icd9code.asp](http://www.cms.hhs.gov/medlearn/icd9code.asp). Look in the box labeled “Effective 10/1/2005” and download Table 6A, New Diagnostic Codes (pdf 32kb), Table 6C, Invalid Diagnosis Codes (pdf 27kb), and Table 6E, Revised Diagnosis Code Titles (pdf 117kb).
- Economedix will hold two teleconferences this month. The first, on October 12, is “Scheduling Techniques for Improved Productivity.” The second, on October 26, is “ICD-9-CM Coding & ICD Changes for 2006.” For more information and to register, go to <http://yourmedpractice.com/ACS>.
- ACS will sponsor basic and advanced coding workshops for surgeons and their office staff on October 17 and 18 at Clinical Congress in San Francisco, CA. Also at Clinical Congress, a practice management course entitled “Charting a Sound Course for Surgical Practices” will be presented October 17. Advance registration has closed but spaces may still be available at on-site registration.

#### **November**

- Economedix will hold three teleconferences this month. The first, on November 2, is “E&M Coding...Beyond the Basics.” The second, on November 16, is “CPT Coding & 2006 Updates for Surgeons.” The third, on November 30, is “Building a Bottom-Line Budget for 2006.” For more information and to register, go to <http://yourmedpractice.com/ACS>.

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**The surgeon is doing the approach for a spinal procedure for a neurosurgeon. Should the code for the partial vertebral body excision procedure with a -62 modifier (two surgeons) be used, or is there a separate procedure code?**

A partial vertebral body excision is one of many spinal codes that can be reported with a -62 modifier. It is important that the neurosurgeon and general surgeon agree to use the same code(s) with a modifier -62 attached and that each surgeon dictates a report for his or her part of the operation. Follow the introductory notes in CPT for the spine and each subsection under the spine for guidance on which codes may have a -62 modifier attached to them.

Remember that in many instances, the neurosurgeon will report codes in addition to the codes the general surgeon reports. It is also possible that the general surgeon will serve as an assistant surgeon on some procedures. If this is the case, he or she should bill the approach with a -62 modifier and other services with a modifier -80 (assistant surgeon) or modifier -82 (assistant surgeon when qualified resident not available). The operative report for the general surgeon should cover only the part of the operation reported with a -62 modifier; the remainder of the operation will only be covered in the neurosurgeon's report.

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**How should I report repair of a scar on the trunk?**

A repair of a scar usually includes excision of a benign lesion and may require an intermediate or complex repair. You would choose the appropriate anatomical site and size from codes 11400-11446. For lesions requiring more than simple closure, report the excision and the appropriate intermediate (codes 12031-12057) or complex repair (codes 13100-13153). Note that full thickness repairs of the lip are located in codes 40650-40654, and full thickness repairs of the eyelid are located in codes 67961-67975.

If you are reporting more than one repair, add the lengths together as long as they are described by the same code. For example, repairing separate scars on the cheek and forehead

would both be covered by codes 13131-13133, so their lengths would be added and only one code reported.

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**What is the diagnostic code for changing a generator for a pacemaker because of a recall?**

ICD-9-CM (*International Classification of Diseases, Ninth Revision, Clinical Modification*) code 996.01 is the code for the problem presented. Codes 996.01 through 996.59 are all mechanical complications of various devices, implants, or grafts. Surgeons doing replacement insertion of any type should be sure that the billing staff knows who should pay for the surgery. The manufacturer of the device should pay for replacements resulting from recalls. If you are going to bill the manufacturer, be sure to follow the instructions provided by the manufacturer.

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**Can two surgeons in the same practice assist each other?**

Yes, of course they can, if assistance is medically necessary. The surgeon who assists reports the procedure code with a modifier -80 (or modifier -82, if they are at a teaching institution and no qualified resident is available).

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**How do I report a situation where a patient had to be returned to the operating room to control bleeding and/or to evacuate a hematoma following mastectomy?**

You should report code 35820, *Exploration for postoperative hemorrhage, thrombosis or infection; chest*, along with modifier -78, *Return to the operating room for a related procedure during the postoperative period*. That -78 modifier has two functions. First, it shows acknowledgment on the physician's behalf that, "I know this occurred during the postoperative period of the original mastectomy, but, because it required a return trip to the operating room, it is enough work that the surgeon ought to get paid." Second, the global period gets reset so that the second surgery becomes the beginning of the global period. Notice that there are identical

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codes for the neck, abdomen, and extremity in the series of codes 35800-35860.

**The surgeon attempted, but could not complete, surgery on a patient who had extensive internal and external hemorrhoids. A month later, the patient returned to the operating room for a successful hemorrhoidectomy. How should I code the second surgery?**

Use code 46260, *Hemorrhoidectomy, internal and external, complex or extensive*, and attach a modifier -78, *Return to the operating room for a related procedure during the postoperative period*, if you are still in the global period for the first procedure.

**How do I bill for a recurrent tumor after mastectomy? I normally would bill a lumpectomy or mastectomy code, but the patient has had a mastectomy so there is no breast tissue.**

Your instinct is quite right. If there is no breast tissue, you cannot say that breast tissue was removed. Report code 21555, *Excision tumor, soft tissue of neck or thorax; subcutaneous*, or code 21556, *Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular*.

**What code do I use to report the excision of a lesion lateral to the pectoralis muscle?**

If it was in breast tissue, use code 19160, *Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmenectomy)*. If it was in the thorax, use either code 21555 or code 21556. (See the previous question for their definitions.) If you cannot tell from the operative report whether it was in the breast or thorax or, if in the thorax, how deep it was, ask the surgeon.

**Why do we not always get paid for conscious sedation?**

First, be sure you are billing appropriately. The codes to use are 99141, *Sedation with or without analgesia (conscious sedation); intravenous, intramuscular or inhalation*, or 99142,

*Sedation with or without analgesia (conscious sedation); oral, rectal and/or intranasal*. Then, be sure you do not bill for conscious sedation with one of the codes in CPT Appendix G, Summary of CPT codes, which includes conscious sedation. However, please note that Medicare and some other payors will not pay the surgeon for conscious sedation because it is considered an inherent part of the procedure. [Q]