Socioeconomic tips of the month

Frequently asked coding questions

Q. I am having problems coding and obtaining reimbursement for the creation and repairs of fistulas and grafts for dialysis access. According to the guidelines for vascular access, established by the Dialysis Outcomes Quality Initiative (DOQI), native fistulas (code 36821) should be attempted in most cases. If native fistulas are not possible or fail, prosthetic grafts (code 35830) or an open revision of an arteriovenous fistula, with or without thrombectomy (codes 63831-33), should be considered. In some instances, this becomes a very complex procedure. I would like guidance about how to code for such repairs.

A. We assume that Medicare is the payor for these procedures. If the first fistula fails and you must perform a second procedure, report the procedure actually performed in both instances with a modifier appended to the second code to indicate that the return to the operating room was for a related procedure (modifier -78). The modifier should generate payment for the intraoperative portion of the second procedure and start a new 90-day global period.

When the second procedure is the same as the first, but done at a different location (for example, a wrist fistula fails and a new wrist fistula is performed on the opposite side), modifier –59 (distinct procedural service) should be used to indicate that services are not normally reported together but are appropriate under the circumstances. Among other information modifier –59 gives the payor is that the same procedure was performed during different sessions or patient encounters. It is generally used when the two procedures are performed on the same day, but it is possible that a few carriers may want it used even when the same procedure is done on different days within a global period.

There is no doubt that some procedures can be very intense and time-consuming. Medicare payment policy assumes that a given case was "typical." However, Medicare will reimburse at a higher rate for services that are "significantly greater than usually required" (*Medicare Carriers Manual,* §4822). These services should be reported with modifier –22 (Unusual procedural services). Documentation, which consists of a concise statement of how the service differs from the usual and a copy of the operative report, should accompany the claim. Medicare requires that all documentation be reviewed and a manual decision made about whether to make payment beyond the usual.

Q. A carotid endartectomy (code 35301) was performed on the patient. The procedure was successful, but two days later the patient experienced a postoperative myocardial infarction and needed central venous access (code 36489). Since the central venous line was placed well within Medicare's 90-day global period for code 35301, should I report code 36489 with modifier –79 (unrelated procedure or service by the same physician during the postoperative period)?

Around the corner

November

- The implementation period, during which Medicare will allow claims to be submitted with the 2001 and the 2002 versions of ICD-9-CM diagnosis codes, continues.
- 2002 Medicare fee schedule scheduled for release. Medicare carriers distribute fee schedules to providers.
- *CPT 2002* available.

December

- Postgraduate course on coding, compliance, and reimbursement presented by the ACS during the Society of Laparoendoscopic Surgeons' 10th International Congress and ENDO EXPO on December 5, 2001, in New York, NY. Contact Flor Tilden at 305/665-9959 for registration form.

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A. Technically, you only need to report modifier –79 when the second operation has a 10- or 90-day global period. Modifier –79 does two things: it tells the carrier to only pay for the intraoperative services of the second procedure, and it resets the global period. When the second procedure is a zero-day global, all the services are intraoperative and the length of the global period is not affected.

Q. What code should I use to report a lumpectomy?

A. Since *CPT* does not use the word "lumpectomy," the physician who performed the procedure will need to decide which code best describes the situation. Some codes you could consider are code 19160 (Mastectomy, partial; with axillary lymphadenectomy) and code 19120 (Excision of cyst, fibroadenoma, or other benign or malignant tumor).

Q. How do I code for the removal of infected mesh from the abdominal wall? I was looking at code 49085.

A. Code 49085 (Removal of peritoneal foreign body from peritoneal cavity) is for the peritoneum and not appropriate. You have two options; you could use code 20680 (Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate) or code 49999 (Unlisted procedure, abdomen, peritoneum and omentum). If you use code 49999, you should attach the operative note.

Q. There is some confusion about how to report a stereotatic breast procedure (ABBI or mammotome). Should code 19103 be used when placing a clip, and can you report code 19125 as well? There are some private carriers that will pay for this procedure, but Medicare will not. What can I do?

A. The American Medical Association has stated that code 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) should be reported with the add-on code 19125 (Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion). This revision should appear in *CPT 2002.*

Q. How do we code for debridement of Fournier's gangrene of the scrotum and perineum up to the inguinal canal?

A. For this situation we would suggest the following: use code 55150 (Resection of scrotum) and one of the following for the perineum and inguinal area: codes 11040-44 (Debridement; skin,...), depending on the depth, with modifier –22; code 11000-01 (Debridement of extensive eczematous or infected skin...), based on percentage; or code 22999 (Unlisted procedure, abdomen, musculoskeletal system). If using the unlisted code, you should send your operative note.

Q. How do I code for an EGD with dilation of the pylorus?

A. You should use code 43245 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with dilation of gastric outlet for obstruction, any method) when the code refers to gastric outlet that would be the pylorus. Ω