

Surgical coding across the spectrum

by Linda Barney, MD, FACS; Daniel Nagle, MD, FACS; Sean Roddy, MD, FACS; Mark Savarise, MD, FACS; Christopher Senkowski, MD, FACS; Eric Whitacre, MD, FACS; and Jenny Jackson, MPH

This month's column addresses—and reinforces—important concepts in coding for different types of surgical procedures using a series of fictional cases that cover the following areas: trauma, breast, vascular, gastrointestinal, and hand surgery.*

Trauma surgery

Case: A 30-year-old male involved in a motor vehicle collision arrives at the hospital in shock. He is taken to the operating room (OR), his spleen is removed, and a single segment of small bowel is resected. Damage control techniques leave the bowel disconnected. A temporary closure is applied. The following day, one of the surgeon's partners takes the patient back to the OR and removes additional bowel with a small bowel re-anastomosis and closes the abdomen. Reportable codes include the following:

Day 1:

38100, *Splenectomy; total*

44120–52, *Enterectomy, resection of small intestine; single resection and anastomosis*

99223–57, *Initial hospital care*

Day 2:

44120–58, *Enterectomy, resection of small intestine; single resection and anastomosis*

The initial evaluation of this critically ill patient warrants reporting a high-level initial inpatient evaluation and management (E/M) code. For example, this may be reported with code 99223. The decision for surgery is noted by appending modifier 57 to the E/M code.

The initial operation on Day 1 is reported with the two separate resection codes, 38100 and 44120. Because the enterectomy did not include an anastomosis, the reduced services modifier 52 should be appended to code 44120.

The return visit to the OR by the surgical partner

should be reported with the same enterectomy code that was reported on Day 1, because there is no specific code for closure of the abdomen. Abdominal closure is included in the enterectomy code. Appending modifier 58 to the enterectomy code indicates that the procedure during the postoperative period was planned or anticipated (staged) and more extensive than the original procedure. In this case, your partner is considered an extension of you. Code 49002 cannot be billed when other procedures, such as 44120 in the previous example, are performed. If the procedure on Day 2 is simply to “relook” and close the abdomen, the appropriate code to report is 49002, *Reopening of recent laparotomy*.

If the patient receives critical care services unrelated to the operation (for example, to deal with shock or respiratory failure as a result of the injury), this is reported by totaling the time spent on each calendar day and reporting codes 99291, *Critical care, evaluation and management, first 30-74 minutes*, and add-on code 99292, *each additional 30 minutes*, as appropriate. If all the surgeons are in the same group practice (that is, the surgeons share the same tax identification number), it is important to coordinate the critical care versus the admit codes among the partners who are billing. If negative pressure wound therapy is indicated, code 97605, *Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*, or code 97606, *Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters*, would be reported based on the size of the wound.

Breast surgery

Case: A 58-year-old female undergoes a right breast lumpectomy and sentinel lymph node biopsy for a 1.2 cm moderately differentiated ER/PR positive node

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.

negative infiltrating ductal carcinoma. A multi-gene assay showed the patient would benefit from adjuvant chemotherapy, so she undergoes insertion of a venous access port two weeks following lumpectomy. This falls within the 90-day global billing period following lumpectomy. Reportable codes include the following:

36561–58, Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 or older

77001, Fluoroscopic guidance for central venous access device placement, replacement

or

76937, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites

Insertion of a subcutaneous venous access port is reported with code 36561 and modifier 58 is appended because this is staged or related procedure performed by the same physician within the postoperative global period. A diagnosis of breast cancer (International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9] code 174.0-174.9) is reported.

If imaging guidance is required for port placement, this may be reported with code 77001 for fluoroscopic guidance or 76937 for ultrasound guidance. Note that use of ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is used. Either the surgeon or the radiologist may report the guidance code.

Case: A 78-year-old female undergoes a left simple mastectomy and sentinel lymph node biopsy for extensive ductal carcinoma in situ of the left breast. The evening of the surgery, the patient develops swelling, pain, and ecchymosis over the left chest wall with copious bloody drainage in the closed suction drain. Examination shows a post-mastectomy hematoma and the patient undergoes surgical evacuation of the hematoma in the operating room that night. Reportable codes:

35820–78, Exploration for postoperative hemorrhage, thrombosis or infection; chest

Evacuation of a hematoma of the chest is reported with code 35820 and modifier 78 is appended because this occurred during the global period of the mastectomy and was an unexpected return to the operating room.

Vascular surgery

Case: A 68-year-old male nursing home resident who has never been seen in the surgeon's office has a profound ischemic rest pain in the right lower extremity. Angiography demonstrates severe infrapopliteal trifurcation occlusive disease with reconstitution of the anterior tibial artery. He has preoperative vein mapping, which demonstrates adequate caliber saphenous vein. The surgeon decides to perform a distal bypass with reverse saphenous vein. Reportable codes include the following:

Day 1:

9920X, Office or other outpatient visit for the evaluation and management of a new patient

Day 2:

36246, Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

75625, Aortography, abdominal, by serialography, radiological supervision and interpretation

75710, Angiography, extremity, unilateral, radiological supervision and interpretation

One week later:

9921X, Office or other outpatient visit for the evaluation and management of an established patient

93971, Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Next day:

35566, Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

Due to the fact that this patient has never been seen before in your office, the office visit is reported with a code for office visit of a new patient (99201-99205), selected based on the level of service documented.

The next day the surgeon reports code 36246 for the left femoral puncture with non-selective aortic catheterization followed by selective catheterization of the right common iliac, and then the right external iliac artery constituting a second order catheterization below the diaphragm. Report code 75625 for the aortogram, and code 75710 for unilateral leg angiogram.

One week later, the patient returns to the office for a follow-up visit to discuss the results of his angiogram. This is reported with a code for office visit of an established patient (99211-99215), selected based on

the level of service documented. At this visit the surgeon decides that he will require surgery and that vein mapping will be necessary. Vein mapping, performed that same day, is reported using the extremity vascular ultrasound codes which are typically divided into “unilateral or limited” or “complete and bilateral.” Vein mapping does not typically involve evaluation of the deep system and, therefore, is classified as “limited.” A unilateral or bilateral vein ultrasound that does not interrogate the deep system is also classified as “limited” and reported with code 93971. The next day, the surgeon performs a distal bypass with reverse saphenous vein, reported with code 35566.

Gastrointestinal surgery

Case: A 45-year-old patient is taken to the OR for a laparoscopic cholecystectomy; at the time of the procedure, the surgeon discovers an umbilical hernia. The surgeon extends the surgical excision in order to repair the umbilical hernia. The reportable code is:

47562, *Laparoscopy, surgical; cholecystectomy*

Only the laparoscopic cholecystectomy is reported. When a laparoscopic cholecystectomy is performed, by convention, the approach is always through the umbilical area. If there is a defect (for example, umbilical hernia), then it is repaired as part of the closure. There is no additional coding for the repair of the umbilical hernia.

Hand surgery

Case: A patient with contracture of the right ring and small finger, metacarpophalangeal joints due to Dupuytren’s disease, undergoes percutaneous needle aponeurotomy to release two cords. The reportable code is:

26040, *Fasciotomy, palmar (eg, Dupuytren’s contracture); percutaneous*

Although two cords were released during this procedure, the Centers for Medicare & Medicaid Services has interpreted this code as applying to the release of one or more palmar cord.

Decision for surgery

Modifier 57 is appended to an E/M service to indicate the “decision for surgery.” Whether the day before surgery or the day of surgery, the E/M service CPT code

must have modifier 57 appended so that the service is not disallowed as part of the surgical package. Modifier 57 is usually used with major procedures (for example, those with a 90-day global period).

Case: A diabetic patient presents in the emergency department with acute cholecystitis. Options are discussed with the patient and the patient’s primary care physician admits the patient for aggressive blood glucose control. You plan to perform a laparoscopic cholecystectomy. Proposed surgery is performed the following day. Reportable codes include the following:

Medicare patient:

9922X–57, *Initial hospital care*

47562, *Laparoscopy, surgical; cholecystectomy*

The initial E/M service is reported with an initial hospital inpatient code (99221–99223), selected based on the level of service documented. Modifier 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. Medicare does not recognize consult codes. It directs that all physicians use the initial inpatient or observation codes (depending on the admission status of the patient); the primary admitting physician appends the E/M codes with the modifier AI. The laparoscopic cholecystectomy is reported with code 47562; no modifier is appended. If a cholangiography is indicated, report code 47563, *Laparoscopy, surgical; cholecystectomy with cholangiography*.

Non-Medicare patient:

9925X–57, *Inpatient consultation for a new or established patient*

47562, *Laparoscopy, surgical; cholecystectomy*

The initial E/M service is reported with a consultation code (99251–99255), selected based on the level of service documented. Modifier 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. The laparoscopic cholecystectomy is reported with code 47562. No modifier is appended. If a cholangiography is indicated, report code 47563, *Laparoscopy, surgical; cholecystectomy with cholangiography*.

E/M on day of surgery

Modifier 25 is appended only to E/M codes, indicating that a “significant, separately identifiable” E/M service is provided on the same day as a “minor”

procedure (for example, those with a 0-day or 10-day global period) per Medicare guidelines.

Case: A patient notes a lump in her right breast the day of her laparoscopic cholecystectomy. The surgeon evaluates the 2 cm periareolar right breast mass and determines that a biopsy is necessary. Reportable codes include the following:

9923X–25, *Subsequent hospital care*
19100, *Biopsy of breast; percutaneous, needle core, not using imaging guidance*

The E/M service for the evaluation of the right breast is unrelated to the cholecystectomy and is reported with a subsequent hospital E/M code (99231-99233), selected based on the level of service documented. Modifier 25 is appended indicating a significant, separately identifiable service. In this case, the ICD-9 code will be different (lump or mass in breast, 611.72). The breast biopsy procedure, reported with code 19100, does not take modifier 25.

Procedures in the postoperative global periods

Case: A 53-year-old woman has undergone a unilateral mastectomy. Ten days later, the surgical site remains open and unhealed. She returns to the office and a wound vac is placed.

For Medicare claims, the global surgical package includes treatment of all complications related to the surgery, unless there is a return to the operating room or procedure room (as defined by CMS). Thus, if the surgical site of a mastectomy patient becomes infected, requiring placement of a wound vac in the office, this procedure is not separately reportable, unless performed in a CMS-approved procedure room.

Some payors may use Medicare rules in this situation, but many do not. Thus, if a wound vac is placed in the office, for a non-Medicare patient, the reportable procedure is as follows:

97605–78, *Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*

Diagnosis coding

Is a lesion of uncertain diagnosis reported with ICD-9 code 238.2, *skin neoplasm of uncertain behavior*?

If a surgeon is unsure of a diagnosis, the ICD-9 code

should not be selected until after the pathology report is complete. ICD-9 code 238.2 is a definitive diagnosis. A diagnosis of uncertain behavior may include lesions such as dysplastic nevi and congenital giant pigmented nevi. ICD-9 code 238.2 should not be used if the diagnosis is not yet known.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, excluding holidays. Q

Editor's note

Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.

Dr. Barney is associate professor and associate program director for general surgery, department of surgery, Wright State University Boonshoft School of Medicine, and member, Wright State Surgeons, Miami Valley Hospital, Dayton, OH. She is the ACS advisor at the American Medical Association CPT Editorial Panel meetings.

Dr. Nagle is a hand surgeon in private practice in Chicago, IL. He is immediate past-president of the American Society for Surgery of the Hand and professor of clinical orthopaedic surgery, Northwestern University Feinberg School of Medicine, Chicago.

Dr. Roddy is a vascular and endovascular surgeon with The Vascular Group in Albany, N.Y. He serves as the Society of Vascular Surgery (SVS) CPT Advisor and as chair of the SVS Health Policy Committee. He is also co-author of the SVS Coding Manual and the director for the SVS Coding Course.

Dr. Savarise is a general surgeon in private practice in Sandpoint, ID. He serves on the Advisory Council for General Surgery, and is the ACS alternate advisor at the American Medical Association CPT Editorial Panel meetings.

Dr. Senkowski is professor of surgery and program director, general surgery residency, Mercer University School of Medicine, Savannah, GA. He is the ACS Advisor to the AMA/Specialty Society Relative Value Scale Update Committee.

Dr. Whitacre is a breast surgeon in private practice in Tucson, AZ. He is immediate past-president of the American Society of Breast Surgeons (ASBS) and the ASBS liaison to the ACS General Surgery Coding and Reimbursement Committee.

Ms. Jackson is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.