49082-49084 Separate Peritoneal Procedures for More Accurate Coding

Get ready for vascular and skin changes, too.

Have you ever been baffled trying to distinguish between an acellular dermal replacement and an acellular dermal allograft? You’ll wonder no more, now that CPT 2012 scraps six families of codes in favor of one new skin-substitute-graft family.

We’ve got a look at these changes and more, so read on for tips on how to code your general surgery claims in 2012.

**Distinguish Paracentesis, Lavage**

Prior to Jan. 1, 2012, abdominal paracentesis and peritoneal lavage shared codes — meaning that you couldn’t distinguish which procedure your surgeon actually performed. Plus, you needed to know whether your surgeon was performing an initial service or a subsequent peritoneal procedure, a fact that was often difficult to ascertain from the surgeon’s op note.

CPT® 2012 changes all that by deleting the following codes:

- 49080 — Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial
- 49081 — … subsequent,

and replacing them with the following new codes:

- 49082 — Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
- 49083 — … with imaging guidance
- 49084 — Peritoneal lavage, including imaging guidance, when performed.

“You’ll use one of these new codes when your surgeon diagnoses or treats a patient with accumulated peritoneal fluid or possible internal bleeding,” explains Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, manager of compliance education for the University of Washington Physicians Compliance Program in Seattle.

Open/lap is different: “Remember to use 49084 only for percutaneous lavage,” Bucknam says. For open lavage, report 49000 (Exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]) or 49002 (Reopening of recent laparotomy). For laparoscopic lavage, report 49320 (Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]).

Don’t miss: “Lavage is bundled into exploration except when performed percutaneously. This is a common mistake and costs general surgery practices thousands of dollars in lost revenue,” Bucknam says.
Check Out New Skin Substitute Codes

If you’ve ever reported your surgeon’s skin-substitute grafting, you know how confusing it is to match the skin-substitute product to the proper code family descriptor.

Starting Jan. 1, you’ll no longer need to figure out which family describes which skin-substitute product, because CPT® 2012 deletes the following six code families:

- 15170-+15176 — Acellular dermal replacement …
- 15300-+15321 — Allograft skin for temporary wound closure …
- 15330-+15336 — Acellular dermal allograft …
- 15340-+15341 — Tissue cultured allogeneic skin substitute …
- 15360-+15366 — Tissue cultured allogeneic dermal substitute …
- 15400-+15421 — Xenograft skin [dermal] for temporary wound closure …
- 15430-+15431 — Acellular xenograft implant …

ICD-10

Switch from 567.22 to K65.1 for Peritoneal Abscess

Little changes from ICD-9 to ICD-10 for this condition.

Your surgeon may diagnose a peritoneal abscess when a procedure such as abdominal paracentesis confirms a pocket of infected fluid and pus within the abdominal cavity.

That’s when you’ll turn to 567.22 (Peritoneal abscess) to describe the diagnosis. But when ICD-9 shifts to ICD-10 on Oct. 1, 2013, you’ll need to report the condition with K65.1 (Peritoneal abscess).

**Code cause, if known:** The condition is often caused by a ruptured appendix, ruptured intestinal diverticulum, inflammatory bowel disease, or parasitic infection in the intestines. You should also code those conditions, if documented.

Although an abdominal CT scan will often uncover the abscess, your surgeon may perform a paracentesis procedure or peritoneal lavage to confirm the diagnosis.

**Documentation:** Take note of other similar terms that the physician could use when describing peritoneal abscesses. K65.1 is also applicable to abdominopelvic abscess, abscess (of) omentum, abscess (of) peritoneum, mesenteric abscesses, retrocecal abscess, subdiaphragmatic abscess, subhepatic abscess, and subphrenic abscess.
Instead, you’ll choose the appropriate code based on graft location and size using one of the following new CPT® 2012 codes:

- **15271** — Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq. cm; first 25 sq. cm or less wound surface area
- **+15272** —  ... each additional 25 sq. cm wound surface area or part thereof (List separately in addition to code for primary procedure)
- **15273** — Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children
- **+15274** —  ... each additional 100 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
- **15275** — Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq. cm; first 25 cm or less wound surface area
- **+15276** —  ... each additional 25 sq. cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
- **15277** — Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq. cm; first 100 sq. cm wound surface area, or 1% of body area of infants and children
- **+15278** —  ... each additional 100 sq. cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

These changes should eliminate a concern addressed at last year’s CPT® and RBRVS 2011 Annual Symposium: Apligraf (15340-+15341) has a 90-day global period versus Dermagraft (15360-+15361), which has a 30-day global period, according to Marc Hartstein, deputy director for the Center for Medicare Hospital and Ambulatory Policy Group. That fact created a financial incentive to choose one product over the other — and the CPT® 2012 changes should eliminate that problem.

**There’s more:** CPT® 2012 also modifies 15150-15157 (Tissue cultured epidermis skin autograft …), but keeps other autograft codes unchanged (15040-15136).

CPT® 2012 adds new code +15777 (Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk) (List separately in addition to code for primary procedure).

“Report +15777 only for soft-tissue surgeries, such as breast — don’t use it for implantation procedures that have their own codes, such as +49568 (Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection [List separately in addition to code for the incisional or ventral hernia repair]),” Bucknam cautions.

““You should also not report  +15777 when the surgeon uses products like acellular dermal matrix for purposes such as pericardium or meninges repair — reserve the code for soft tissue,” Bucknam emphasizes.

**Look for 7 New Vascular Codes**

You’ll have four new codes beginning Jan. 1 to report selective catheter placement for renal artery and second order or higher renal artery branches (36251-36254). Also expect three new codes for endovascular placement, repositioning, and removal of an intravascular vena cava filter (37191-37193). We’ll explore these and more CPT 2012 changes in the next issue of General Surgery Coding Alert.

**CPT® 2012**

**99218-99220: Observation Time Guidelines Could Help You Gain Pay**

Also watch for modifier 33.

When CPT® 2011 debuted the subsequent observation care codes 99224-99226, many coders were left scratching their heads. Those new codes featured typical times associated, even though the initial observation care codes 99218-99220 don’t have typical times.

**Get a New Outlook on E/M Time**

The new 2012 edition of your CPT® manual, which takes effect on Jan. 1, will remedy that problem, with the addition of the following typical time guidelines:

(Continued on next page)
Although the specific reasons for the CPT® committee’s inclusion of these codes won’t be crystal clear until the AMA’s November CPT® Symposium, it looks like the addition of typical times could open the door for coding based on time.

“There are only two ways that you can use time as a basis for selecting an E/M code,” says Barbara J. Cobuzzi, MBA, CPC, CEDNT, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. “If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such,” Cobuzzi adds.

New 2012 Modifier May Not Mean Extra Pay

It isn’t every year that CPT® adds new modifiers for your coding and billing needs, so when you see a new one gracing the pages of your 2012 manual, you might get excited — but don’t rejoice just yet.

Modifier 33 (Preventive service) went into effect on Jan. 1, 2011, but it didn’t make it into the 2011 CPT® book due to publishing deadlines, so the modifier will be making its first appearance in the 2012 manual. According to CPT®, you should append the modifier “when the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates.”

**Medicare won’t pay:** Unfortunately, you’re not likely to get any love from your MACs with this new modifier. According to a Q&A on WPS Medicare’s Web site, Medicare does not recognize modifier 33 (www.wpsmedicare.com/part_b/resources/provider_types/awv-faq.shtml).

**General surgery outlook:** The most likely reason a general surgeon would look to modifier 33 is for performing a screening colonoscopy. Not recognizing the modifier shouldn’t be a problem, however, because Medicare expects a HCPCS Level II code without a modifier for this procedure, such as G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

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**Medical Necessity**

### 3 Steps Focus Diagnosis Coding for Your Surgical Claims

Add these tips to your ICD-9 toolbox.

You won’t get paid for your surgeon’s work if you only focus on what he did; you also need to focus on why he did it. Choosing the right ICD-9 code tells the “why” story — and that’s the basis for demonstrating medical necessity for the procedure.

Follow our experts’ tips to make sure you pick the right ICD-9 code to reflect your surgeon’s diagnosis documentation, and to make sure you get paid.

1. **Get the Big Picture**

   The first building block of a well-designed diagnosis coding policy is to adhere to the ICD-9-CM Official Guidelines for Coding and Reporting, says Tricia A. Twombly, BSN, RN, HCS-D, CHCE, senior education consultant and director of coding with Foundation Management Services in Denton, Texas. Not staying up to date with these standard rules can lead to trouble.
The official guidelines are updated each year and usually are available shortly after the annual ICD-9 code changes are made public. You can access the current guidelines at www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf.

**Use outpatient rules:** Note that the rules for outpatient diagnosis coding apply for physician services whether your surgeon performs a procedure in an inpatient or outpatient setting.

**Coder tip:** Read the official guidelines that apply to your specialty periodically as a refresher. “If we only read them when the codes change once a year, it is difficult to absorb and retain that information for an entire year,” says Lisa S. Martin, CPC, CIMC, CPC-I, chargemaster specialist for OSF Healthcare System in Peoria, Ill.

**Keep current:** Whether the official guidelines or the ICD-9 codes themselves, you should use only the most current version when selecting a diagnosis code. “Regardless of the resource, the most important factor is that it is up to date,” Martin says. Using an invalid code will always trigger a denial.

2. Begin in the Index; Proceed to the Tabular List

The first general coding guidance you’ll find in the ICD-9 official guidelines is to always use both the alphabetic index (Volume 2) and the tabular list (Volume 1). Relying on just one section “leads to errors in code assignments and less specificity in code selection,” according to the guidelines.

**Start with index:** You should always begin your code search by first consulting the alphabetic index, which is arranged by condition.

When you have narrowed your search using the index, cross-reference the codes using the tabular listings, and read the precise definition of your tentative code selection. The tabular listing typically provides additional information such as other common terms that report to the same code, or terms that are excluded from the code.

If you code directly from the alphabetic index, you’ll miss valuable information that will help you pinpoint the exact code you need. That’s why you should always read the notes in the ICD-9 manual that apply to the code you’re considering, says Denae M. Merrill, CPC, HCC coding specialist in Holland, Mich.

**Coder tip:** Don’t be afraid to write a lot of your own notes in the margins and make good use of your highlighters, says Martin. “I even make notes in the index because where you initially expect to find something is where you will search again in the future.”

**Alert:** Your surgical practice might have a “cheat sheet” that lists common conditions that your surgeon treats and the associated ICD-9 codes. Take care when using cheat sheets, Merrill cautions. They can be helpful as long as you don’t rely on them too heavily. And you absolutely must be sure you update them regularly.

3. Be Specific

You must always report the most specific ICD-9 code you can, based on the surgeon’s documentation. That means reporting codes “at their highest number of digits available,” according to the official guidelines.

(Continued on next page)

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**Hone Your ICD-9 Coding Skills With This Example**

You just studied tips for accurate ICD-9 coding in “3 Steps Focus Diagnosis Coding for Your Surgical Claims.” Now you can practice those skills with the following example:

**Scenario:** Your general surgeon excises an external thrombosed hemorrhoid (46320, Excision of thrombosed hemorrhoid, external) in a patient at 28 weeks gestation. What ICD-9 code should you use?

**Solution:** If you selected 455.4 (External thrombosed hemorrhoids) because you checked only the alphabetic index, you would be wrong. Once you turn to the tabular list, you’ll see that category 455 (Hemorrhoids) excludes “that complicating pregnancy, childbirth, or the puerperium (671.8).”

When you look up 671.8 (Other venous complications), you’ll read that the code lists “Hemorrhoids” as an example of this condition. You’ll also notice that ICD-9 lists the code with a red dot — meaning you’ll need to add a digit.

**Final answer:** In this case, you should choose 671.83 to indicate that this is an antepartum condition or complication. □

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**You Be the Coder**

**Anatomy Answers Cecectomy Question**

**Question:** The surgical note says that the surgeon performed a laparoscopic “partial cecectomy,” which involved stapling across the cecum. How should we code the procedure?

**Answer:** See page 87. □
In other words, you must use four- or five-digit codes when they’re available. You should never report a category (three-digit) or subcategory (four-digit) code when ICD-9 lists more specific codes under those headings — your claim will reject if you do.

Coder tip: Although there’s no standard format for ICD-9 books, many editions have an indicator that a code requires additional digits. Use these reminders if they’re available to you.

Don’t be too specific: Reporting to the highest degree of specificity doesn’t mean guessing at information not in the medical record or coding preliminary diagnoses as final. If you don’t have specific information, you’ll need to use a “not otherwise specified” (NOS) or “unspecified” code using the proper number of digits.

Regarding preliminary diagnoses, you shouldn’t code “rule out,” “suspected,” “probable” or “questionable” statements in the medical record. If you don’t have a definitive diagnosis, “look for any signs or symptoms that the patient has been having,” Merrill says.

Caution: Don’t use unspecified codes for a condition that’s specified in the medical record, but doesn’t have a specific ICD-9 code. Instead, you should select a code that uses the terminology “other,” “other specified,” or “not elsewhere classifiable (NEC).” In other words, the lack of specificity lies in ICD-9, not in the documentation.

Coder tip: Often, but not always, NEC codes end with a final digit of “8,” while NOS codes end with a final digit of “9.”

49321: Stick to Anatomic Site for Code Selection

Question:
Can we use 49321 for a laparoscopic liver biopsy to avoid using an “unlisted” code?

Tennessee Subscriber

Answer:
No, you should not report a laparoscopic liver biopsy using 49321 (Laparoscopy, surgical; with biopsy [single or multiple]). Instead, you should report the service using 47379 (Unlisted laparoscopic procedure, liver).

Here’s why: 49321 is in the CPT subsection for “Abdomen, peritoneum, and omentum” (49000-49999). Because CPT provides specific codes in the “Liver” subsection (47000-47399), you should use one of those codes for a liver procedure. Because CPT® doesn’t provide a specific laparoscopic liver biopsy code, you need to choose the unlisted procedure code.

Furthermore: The AMA has weighed in on this coding question in two CPT Assistant references. CPT Assistant Aug. 2006 indicates that the best code for the procedure is 47379, while Dec. 2007 also states that you should use 47379 for a laparoscopic wedge liver biopsy performed in addition to a laparoscopic cholecystectomy (47562-47564, Laparoscopy, surgical; cholecystectomy …).

You should find no advantage in avoiding “unlisted” codes. Sometimes, those are the best code to describe a service, and you should use them unless a specific payer requires a different code for a particular procedure.

Know GC Rules for Resident Surgical Assists

Question:
When a resident assists a surgeon in a teaching hospital, do we need to add modifier GC to the procedure code for surgery or is that a modifier for E/M codes only?

Florida Subscriber

Answer:
Yes, you should append modifier GC (This service has been performed in part by a resident under the direction of a teaching physician) to surgical procedure codes when a resident assists a surgeon in a teaching hospital.

Modifier GC is not only for E/M codes. The modifier indicates that a resident provided the procedure under a teaching physician’s direction.

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Know TP rules: When your surgeon works as a “teaching physician” (TP) and supervises a resident’s services in a clinic or hospital setting, you will have to report your physician’s work using the TP rules, according to the Medicare Carriers Manual (MCM), section 15016.

The MCM defines a resident as an intern or fellow who’s enrolled in an accredited graduate medical education (GME) program.

When you report surgeries, you should make sure the surgeon documents that he functioned as a TP. That means the TP was present for the entire procedure — or present for the key and/or critical portions of the procedure and immediately available for the rest of the procedure (such as present in the operating suite).

Bottom line: Use modifier GC when you have documentation that your surgeon functioned as a TP for a resident for both E/M and surgical procedures.

10021/21011 Bundles Limit Coding

Question:
Our surgeon performed a fine needle aspiration followed by an excision of a 1.5 cm soft tissue mass of the face. Can we bill both the 10021 and the 21011 services?

Answer:
No, you should not bill 10021 (Fine needle aspiration; without imaging guidance) and 21011 (Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm) for the two procedures directed at the same mass. Instead, you should report only the most extensive procedure: 21011.

Here’s why: CMS bundles FNA and soft tissue tumor codes under the “sequential procedures” policy of the Correct Coding Initiative (CCI). The guidance states, “On occasions where it is necessary that the same provider attempts several procedures in direct succession at a patient encounter to accomplish the same end, only the procedure that successfully accomplishes the expected result is reported.”

CCI lists FNA 10021 as a column 2 code with 21011 indicating that you should not separately bill an FNA when the surgeon follows with another soft tissue tumor excision procedure at the same site.

Exception: If the surgeon provides documentation that the FNA and soft tissue tumor excision are for separate sites, you can code both services. In that case, you would need to override the CCI edit pair by appending modifier 59 (Distinct procedural service) to the FNA code. Your case does not meet the criteria to “unbundle” the edit pair using modifier 59.

Use Inclusive Code for Whipple Resection

Question:
Our surgeon performed a “Whipple Resection,” which included creating an opening between the pancreas and jejunum. How should we code the procedure?

Answer:
A complete op note would be necessary to answer this question with certainty, but the best code for the procedure you describe is likely 48150 (Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy [Whipple-type procedure]; with pancreateojunostomy).

The alternate code for the complex Whipple resection is 48152 (…without pancreateojunostomy). Because you describe creating an opening between the pancreas and jejunum, 48150 is the better code.

Watch bundles: Whipple-type procedures involve removing several organs or parts of organs, so you need to exercise caution about bundling issues. For instance, the Correct Coding Initiative (CCI) lists cholecystectomy codes 47600–47620 as column 2 codes with 48150. The modifier indicator of “0” means that you cannot override the edit pair under any circumstances.

Reader Questions and You Be the Coder were prepared with the assistance of Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, manager of compliance education for the University of Washington Physicians Compliance Program.
We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to General Surgery coding and reimbursement to the Editor indicated below.

Mary Compton, PhD, CPC
maryc@codinginstitute.com
Editor and Publisher

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Content Director

The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713 Tel: 1-877-912-1691 Fax: (800) 508-2592 service@codinginstitute.com

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Ellen Garver, CPC ellen@codinginstitute.com
Editor

Marcella Bucknam, CPC, CCS-P, CPC-H, CCA Consulting Editor

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