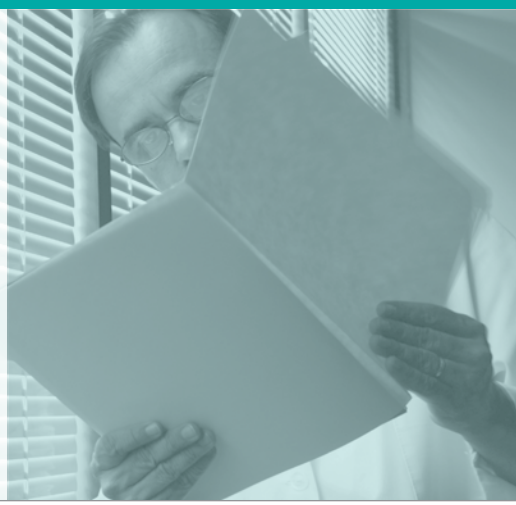
Frequently asked questions about CPT coding



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Experts agree that correct Current Procedural Terminology (CPT)* coding may be the single most important area for surgical practice improvement. However, keeping up with the constant changes in claims coding and billing rules can be costly and time-consuming. This column lists several frequently asked questions and the correct coding responses.

How do I report an open colon resection and colorectal anastomosis with loop ileostomy for fecal diversion?

You should report CPT code 44146 (see Table 1, page 43). Although the CPT descriptor includes the term "colostomy," the Medicare physician fee schedule work relative value unit (RVU) for this code is based on creation of either a colostomy or an ileostomy. If this same procedure was performed laparoscopically, the correct code to report would be 44208, *Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy.* It is incorrect to report a code for ileostomy or jejunostomy (44310 or 44187) with a partial colectomy code (for example, 44145 or 44207) for this procedure, as doing so would be unbundling.

What code do I report for a laparoscopic appendectomy for perforated appendicitis?

Two codes differentiate an open appendectomy without rupture (44950) and with rupture (44960). However, only one code applies to laparoscopic appendectomy (44970), and it is used to report a laparoscopic appendectomy for either scenario; with rupture or without rupture (see Table 2, page 43).

A 65-year-old female with a remote history of colon cancer undergoes a laparoscopic cholecystectomy for symptomatic cholelithiasis. A concerning lesion is identified on the liver and a laparoscopic biopsy is performed. How is this coded?

If a laparoscopic biopsy of the liver is performed at the same time as another laparoscopic procedure, report unlisted code 47379, as there is no CPT code for a laparoscopic liver biopsy (see Table 3, page 43). It would be inappropriate to report 49321, *Laparoscopy, surgical; with biopsy (single or multiple).* Code 49321 is reported only when a biopsy is the only procedure performed. If these procedures were performed via an open approach, code 47600 (open cholecystectomy) would be reported with code 47001, *Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (List separately in addition to code for primary procedure),* or code 47100, *Biopsy of liver, wedge,* as appropriate. Unlisted codes have a "YYY" global period, which indicates they are contractor-priced and require documentation that provides pertinent information, including an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

TABLE 1. COLECTOMY

CPT code(s) to report	Descriptor	Global period	Work RVU	Total Relative Value Unit (RVU)
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	090	35.30	61.44

TABLE 2. CODING FOR LAPAROSCOPIC APPENDECTOMY

CPT code(s) to report	Descriptor	Global period	Work RVU	Total RVU
44970	Laparoscopy, surgical, appendectomy	090	9.45	17.40

TABLE 3. LAPAROSCOPIC LIVER BIOPSY

CPT code(s) to report	Descriptor	Global period	Work RVU	Total RVU
47562	Laparoscopy, surgical; cholecystectomy	090	10.47	19.04
47379-51	Unlisted laparoscopic procedure, liver	YYY	0.00	0.00

How do I report removal of a lipoma of the spermatic cord and repair of a reducible inguinal hernia performed at the same time, through the same incision?

For this clinical scenario, report only the hernia repair code 49505 (see Table 4, page 44). A lipoma or preperitoneal fat that is within the hernia sac or part of the hernia repair would not be separately reported. Code 55520, *Excision of lesion of spermatic cord (separate procedure),* is a "separate procedure."

Coding tip: When a procedure that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session, different procedure or operation, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

How do I report the following excisional debridement work that was performed in a facility setting: 30 square centimeters (sq cm), subcutaneous, right thigh; 45 sq cm subfascial, separate site right thigh; 25 sq cm, subcutaneous, left thigh; and 45 sq cm subfascial, separate site, left thigh?

Excisional wound debridement is reported by depth of tissue removed and by total surface area of the wound(s). If multiple separate wounds require different depths of debridement, calculate a total wound surface area for all wounds at each depth. When choosing codes to report, keep in mind that the CPT code numbers for excisional debridement are out of sequence. The codes are reported in descending order of total RVU.

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TABLE 4. HERNIA REPAIR WITH SPERMATIC CORD LESION

CPT code(s) to report	Descriptor	Global period	Work RVU	Total RVU
49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	15.03

TABLE 5. DEBRIDEMENT

CPT code(s) to report	Descriptor	Global period	Work RVU	Total RVU
47562	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less	000	2.70	4.47
47379-51	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	000	1.01	1.78
+11046 x4 units	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	ZZZ	1.03 x4 units	1.62 x4 units
+11045 x2 units	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	ZZZ	0.50 x2 units	0.76 x2 units

+ = add-on code

TABLE 6. HERNIA

CPT code(s) to report	Descriptor	Global period	Work RVU	Total RVU
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	090	23.00	43.56
15734-59	Muscle, myocutaneous, or fasciocutaneous flap; trunk	090	23.00	43.56
49565-51	Repair recurrent incisional or ventral hernia; reducible	090	12.37	22.20
+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)	ZZZ	4.88	7.76

+ = add-on code

CODING WORKSHOPS

More information about the 2018 ACS coding workshops is on the ACS website at *facs.org/advocacy/practmanagement/workshops.*

Upcoming workshops:

- Nashville, TN, August 9–10
- Chicago, IL, November 1–3 (includes a third day devoted to trauma and critical care coding)

For the clinical scenario in the question, the subcutaneous debridement on the right and left thighs totals 55 sq cm of wound surface area and is reported with 11042 for the first 20 sq cm and two units of 11045 for the additional 20 sq cm and the additional remaining 15 sq cm (20 + 20 + 15 = 55). The subfascial debridement totals 90 sq cm of wound surface area and is reported with 11043 for the first 20 sq cm and four units of 11046 for the additional 70 sq cm (20 + 20 + 20 + 10 = 70). There is a National Correct Coding Initiative (NCCI) edit for the code pair 11042/11043, so modifier 59 (*Distinct procedural services)* should be appended to 11042 to indicate the subcutaneous debridement was performed at separate sites from the subfascial debridement. Because 11045 and 11046 are add-on codes and additionally do not have an NCCI edit with the other codes to be reported, there is no need to append modifier 59 (see Table 5, page 44).

Coding tip: If only one wound is debrided at various depths, report the code that represents the deepest level of debridement, and use the total wound surface area for any and all types of debridement. For example, a single wound requiring 10 sq cm of subfascial debridement and 10 sq cm of subcutaneous debridement would be reported with 11043.

What code is reported for repair of a recurrent, reducible ventral hernia with mesh and both a left-sided and right-sided component separation?

Report 49565 for the hernia repair and 49568 for implantation of mesh. Medicare guidelines do not allow use of modifier 50 *(Bilateral procedure)* with 15734; therefore, for the work of bilateral component separation, report one unit of 15734 plus a second unit of 15734 with modifier 59 appended (see Table 6, page 44). Note that code 15734 may only be reported once for each side because it represents a musculofascial flap involving the mobilization of the rectus muscle whether performed with anterior or posterior release.

Coding tip: Report modifier 59 instead of modifier 51 on the code(s) with lower total RVU for code pairs that have an NCCI edit or to indicate that the same procedure was performed at a different anatomic site (for example, right and left musculofascial flaps). If no NCCI edit exists for a code pair, then append modifier 51 to the code(s) with the lower total RVU.

Learn more

Learn more about correct coding at an American College of Surgeons General Surgery Coding Workshop (see box, this page). By attending a coding workshop, you will learn how to report surgical procedures and medical services and will have access to the tools necessary to succeed, including a coding workbook with checklists, resource guides, templates, and examples to keep for future reference. Physicians receive up to 6.5 *AMA PRA Category 1 Credits*™ for each day of participation. ♦