ACS Coding Hotline: Cholecystectomy questions

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This column lists some frequently asked questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the responses. As a benefit of membership in the College, ACS members and their staff may consult the hotline 10 times annually without charge. If your office has coding questions, contact the Coding Hotline at 800/227-7911 between 8:00 am and 6:00 pm Mountain Time, holidays excluded.

The surgeon performed an open cholecystectomy with cholangiography. When the procedure was done, there was a fistula into the colon, so he repaired the colon. We are coding this surgery with code 47605, *Cholecystectomy; with cholangiography,* and code 44604, *Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy.* The diagnosis for the cholecystectomy was stones. Should the surgeon give the diagnosis of fistula in gallbladder?

The use of the two CPT codes is correct. The International Classification of Diseases, Ninth Revision (ICD-9), diagnosis for the gallbladder problem is 574.00. The fistula should have a diagnosis of 575.5.

The surgeon performed a laparoscopic cholecystectomy with removal of a common bile duct lymph node. Do I also code 38747, *Abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and vena caval nodes (list separately in addition to code for primary procedure*)?

Code for the cholecystectomy using 47562, *Laparoscopy, surgical; cholecystectomy*. There is no extra coding for removal of the common bile duct lymph node.

The procedures dictated in the operative note are cholecystectomy with choledochoenterostomy and a gastrojejunostomy. In the note, the surgeon stated that the gastrojejunostomy was performed 30 cm away from where the choledochoenterostomy was completed. Which codes should be used?

The codes for this surgery would be 47612, *Cholecystectomy with exploration of common duct; with choledochoenterostomy,* and 43820, *Gastrojejunostomy; without vagotomy.*

The surgeon planned a laparoscopic cholecystectomy but encountered problems that necessitated switching to an open procedure. The surgeon also did a partial

Around the corner

The 2009 ACS-sponsored Coding Workshops schedule will be published soon on our Web site at *www.facs.org/ahp/workshops.*

November

- Be sure to look for practice management teleconferences from Economedix. To register, go to our Web site at *http://www.facs.org/ahp/workshops/teleconferences.html*.
- CPT Coding & 2009 Update for Doctors and Staff will convene November 12. Building a Bottom-Line Budget for 2009 will be held November 26.

PEG tube coding tips

- If the surgeon replaces the percutaneous endoscopic gastrostomy (PEG) tube because of clogging or other factors, code 43760, *Change of gastrostomy tube*, if there is no image guidance.
- If the surgeon performs a replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injections(s), image documentation and report, use 49450.
- If the surgeon encounters a problem replacing the PEG tube and uses endoscopy to determine the problem and assist in the tube removal, it would be appropriate to code a diagnostic endoscopy code and 43760, C*hange of gastrostomy tube*.
- You cannot report a separate code for simple PEG tube removal. Use the appropriate evaluation and management codes. Removing a PEG tube does not qualify as foreign body removal, so 43247, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body* would not be appropriate. Only use code 43247 if a scope is used to retrieve a broken portion of a PEG tube that remains in the stomach.

colectomy. We are coding 44144, *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula*, and 47600, *Cholecystectomy,* but the surgeon also wants to know if 49320, *Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure),* for the laparoscopic portion of the procedure can be coded.

You generally will code procedures with the highest relative value units first.[†] Use 44144, *Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula*. The relevant ICD-9 diagnosis should also be listed on the first line of the claim form. Then code 47600, *Cholecystectomy*. Remember, you should not report both the open and laparoscopic codes for the same procedure. If the surgeon converts a laparoscopic procedure to an open procedure, you should report the open procedure code only. You can use the code V64.41, *Laparoscopic surgical procedure converted to open procedure,* to show the conversion to open procedure.

The patient underwent a laparoscopic cholecystectomy, but the surgeon also did an open cholangiogram. How would I code these two procedures?

The cholecystectomy code that includes the cholangiogram is 47563. Code the laparoscopic code, 47563, *Laparoscopy, surgical; cholecystectomy with cholangiography,* with the –22 modifier (*Increased Procedural Services*) to indicate that the cholangiography was done as an open procedure and include a detailed description of the situation in the operative note.

The patient had a laparoscopic cholecystectomy, 47563, and within the global period (90 days) of this procedure was taken back to the operating room for a Whipple procedure, 48150. The surgeon is also coding the +44015, *Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (list separately in addition to primary procedure),* and placed the –79 modifier on both of these codes. Is this the correct coding?

Coding the 48150, *Pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy,* with the –79 modifier (*Unrelated procedure or service by the same physician during the postoperative period*) is correct. Add-on codes are exempt from modifiers so the –79 modifier is not necessary with +44015. Guidelines for add-on codes can be found in the Introduction of the Professional Edition of the CPT. Ω

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[†]*Medicare Correct Coding Guide*. Salt Lake City, UT: Ingenix; 2007 (ISBN 1-978-56337-949-9).