ACS Coding Hotline: Operative report questions

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This column presents questions recently posed to the American College of Surgeons Coding Hotline and their responses. ACS Fellows and their staff may consult the hotline five times annually without charge. If your office has coding questions, please contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, Monday through Friday, holidays excluded.

Our surgeon had to bring a patient back to the operating room to perform a postoperative incision and drainage, complex, for a wound infection. We coded this procedure 10180, *Incision and drainage, complex, postoperative wound infection*. Can we bill for this service during the global period of the original surgery?

When a return to the operating room is necessary during a global surgery period for the incision and drainage of a complex postoperative wound infection, append modifier –78, *Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*, to 10180.

The dictated operative report states that the following procedures were performed: (1) laparoscopic gastric bypass, Roux-en-Y; (2) laparoscopic tube gastrostomy; (3) insertion of percutaneous pain pump; and (4) upper gastrointestinal endoscopy with endoscopic retrieval of percutaneous placed pull wire. The entire operation was done with a voice-operated robotic arm to control the laparoscopic movement. What would be the appropriate codes for these procedures?

The correct coding is 43644, *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*. Diagnostic EGD (esophagogastroduodenoscopy) and 43653 (laparoscopic gastrostomy) are both included in the procedure according to Current Procedural Terminology (CPT)* guidelines and National Correct Coding Initiative (NCCI) edits. Use of robotic equipment is inherent in the procedure.

The operative report indicates that the surgeon performed a direct laryngoscopy, an esophagoscopy, and a rigid bronchoscopy. Can all three of these procedures be coded separately or should they be bundled?

You can report all three as long as your documentation supports that each procedure was a distinct and separate procedure. CPT code 31525,

Around the corner

- For dates and locations of the 2009 ACS-sponsored Coding Workshop schedule, visit *http://www.facs.org/ahp/workshops/index.html*. Online registration is also available at this Web site. The next coding workshops will take place July 9 and 10 in Chicago, IL. The College is sponsoring another set of workshops on August 27 and 29 in Los Angeles, CA.
- Be sure to catch the practice management webcasts that the College sponsors every other Wednesday. To register and see the schedule please go to *http://www.facs.org/ahp/workshops/teleconferences.html*.
- For help with coding, the ACS sponsors "Coding Today" at *http://acs.codingtoday.com/*.

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Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn, is included in 31622, *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)*. 31525 may be unbundled from 31622 if you can justify the use of an appropriate modifier (–59—see below). If you are unable to justify the use of a modifier, you may only bill 31622. If you bill both, 31525 should receive the modifier.

CPT code 31525 is included in 43200, *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*. 31525 may be unbundled from 43200 if you can justify the use of an appropriate modifier. If you are unable to justify the use of a modifier, you may only bill 43200. If you bill both, 31525 should receive the modifier. You would have to use the modifier –59, *Distinct procedural service*. CPT code 43200 and 31622 may be reported together using the modifier –51, *Multiple procedures*.

Our surgeon removed three breast masses from the patient's left breast. The masses were excised from two separate sites. How should we code for this operation?

You would code 19120, *Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions*. Report a second procedure 19120–59, because it required a separate incision through a different excision site. Modifier –59 is used to indicate a separate site was excised. It would be advisable to include either a clear operative dictation or a cover letter stating two distinct incisions were made.

The operative report indicates that the surgeon excised three nevi involving the right side of the neck, ranging from 0.75 to 2.5 cm in size. The surgeon also removed approximately 10 skin tags, ranging from 2 to 5 mm in size, from the neck. The three nevi were 0.75 cm, 2 .0 cm, and 2.5 cm. How do you code for multiple excisions of different sizes? Pathology states that all of the specimens were benign.

Resources

Current Procedural Terminology 2009, Professional Edition, American Medical Association (AMA), Chicago, IL *Principles of CPT Coding, 5th Edition*, AMA.

Code as follows: 11423, *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm*; 11422–51, *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm*; 11421–51, *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm*; and 11200–51, *Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions*. The number of skin tags removed determines the code assignment. Code 11200 refers to 15 or fewer skin tags. When specimens are sent for pathological analysis, coders are advised to wait for pathology results before assigning codes.

If a laparoscopic procedure is performed, but no codes accurately describe the laparoscopic procedure, can the open procedure code be reported?

No, an open procedure code should never be reported to describe a procedure that was performed laparoscopically. If there is not an accurate code descriptor, use the unlisted code, for example, 44238, *Unlisted laparoscopy procedure, intestine (except rectum)*.

Can we code for a laparoscopic lysis of adhesions when a laparoscopically assisted small bowel resection is performed?

Do not report laparoscopic lysis of adhesions in addition to the laparoscopically assisted small bowel resection, as this service is included. Ω