10 Bullets Focus General Surgery Coding for Jan. 1

Catheter changes lead the charge.

You’ll be using CPT® 2013 codes before you know it, so let our experts give you a crash course in what’s new for the coming year that might impact your general surgery practice.

**Big change:** “Continuing the trend to revise catheter coding (CPT® 2012 revised 36245-36248 and added 36251-36254, Selective catheter placement…), CPT® 2013 revises, adds or deletes 18 catheter-related codes,” says Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, audit manager for CHAN Healthcare in Vancouver, Wash.

**Check-Out This Quick-Reference Synopsis**

Peruse this 10-bullet summary to see what’s coming your way in CPT® 2013:

- **Island pedicle flap change:** Expect a revision to 15740 (Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel) that distinguishes the code from 14000-14302 (for adjacent area flaps without clearly defined anatomically named axial vessels).

- **Fluid removal from chest:** CPT® 2013 deletes pneumocentesis and thoracentesis codes 32420-32422, and adds new codes for pleural aspiration (32554-32555, Thoracentesis, needle or catheter; aspiration of the pleural space…) and pleural drainage (32556-32557, Pleural drainage, percutaneous, with insertion of indwelling catheter…) to take their place. Tube thoracostomy 32551 revision specifies that it’s an open procedure. You’ve already read about these changes in “32420-32422 Are Out — Prep 4 New Thoracentesis and Drainage Codes,” General Surgery Coding Alert Vol. 14, No. 12.

- **Catheter introduction:** Codes for vena cava (36010) and extremity artery (36140) catheter introduction will include moderate sedation in CPT® 2013.

- **Cervical, cerebral, and carotid selective catheter placement:** Expect to see eight new codes (36221-+36228, Non-selective/selective catheter placement…), each of which represents both catheter placement and radiological services. Because the new codes include angiography, 75650-75685 will be deleted. Read more about this change in “8 New Codes Merge Catheter Placement + Angiography” on page xxx of this issue.

- **Venipuncture changes:** Revisions to 36400-36410 (Venipuncture …) allow “other qualified health care professionals” to perform the service, not just physicians.

- **Transcatheter foreign body retrieval:** New code 37197 (Transcatheter retrieval, percutaneous, of intravascular foreign body [e.g., fractured venous or arterial catheter], includes radiological supervision and interpretation, and imaging guidance [ultrasound or fluoroscopy], when performed) includes both transcatheter retrieval and... (Continued on page 3)
ICD-10

Follow Expert Advice for 6-Phase Transition Plan

Remember to factor productivity loss into your budget.

The clock is ticking for the Oct. 1, 2014 ICD-10 implementation date — do you have a plan to get ready?

Before you panic, check out this “how-to” advice to prepare for a smooth transition:

Take One Step at a Time

“Education and patience are key,” says Ginger Boyle, M.D., a practicing physician during a CMS National Provider Call entitled, “Preparing Physicians for ICD-10 Implementation.”

This presentation breaks down your ICD-10 transition into the following six phases:

1. Planning
2. Communication and awareness
3. Assessment
4. Operational implementation
5. Testing
6. Transition.

In other words: To begin, you should establish the project structure, responsible parties, and highlight physician and coding champions who can be assets. You should also establish the budget. Be sure to include software upgrades, training needs, and productivity loss/gain.

Then, you should talk to all those involved, which may include office administrative staff, vendors, providers, clearinghouses, payers, and so on.

You need to monitor the impact on the following aspects:

» Personnel: staff, providers
» Claims
» Reimbursement
» Denials.

Bottom line: “Once you create a timeline, you need to stick to it,” Boyle says. CMS finalized the ICD-10 compliance date of Oct. 1, 2014, as stated in the Sept. 5, 2012, Federal Register. When ICD-10-CM goes into effect, you should apply the code set and official guidelines in effect for the date of service reported.

For more information, you can go to the CMS ICD-10 page at URL: www.cms.gov/Medicare/Coding/ICD10/.

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imaging. Consequently, CPT® will delete transcatheter retrieval code 37203 and its related code 75961.

» **Transcatheter therapy infusion:** Thrombolysis codes 37201 (therapy) and 37209 (catheter exchange) that CPT® 2013 deletes are replaced with several more specific, comprehensive codes 37211-37214 (*Transcatheter therapy*…).

» **Transplantation cellular infusions:** New and revised CPT® instruction and codes 38240-38242 (*HPC/

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**CPT® 2013**

**8 New Codes Merge Catheter Placement + Angiography**

Yield to hierarchy to dodge denials.

Following the trend to create more comprehensive vascular codes that include all aspects of a service, CPT® 2013 adds eight new codes you need to know for diagnostic studies of cervicoocerebral arteries.

Anatomically, the new codes relate to vessels in the neck and head, says **Terry A. Fletcher, BS, CPC, CCS-P, CCS, CEMC, CCC, CMSCS, CMC**, of California-based Terry Fletcher Consulting.

Similar to renal angiography codes 36251-36254 added in CPT® 2012, new CPT® 2013 codes 36221-+36228 include catheterization, angiography, and radiological supervision and interpretation.

That’s a significant shift from past coding, which required separate codes for catheter placement and radiological services, Fletcher notes.

Because of this change, CPT® 2013 deletes angiography codes 75650 and 75660-75685 for the carotid, cerebral, vertebral, and cervical arteries, says **Julie Graham, BA, CPC**, coder and compliance specialist for Concentra in Texas.

**What’s included:** Codes 36221-36226, which are primary rather than add-on codes, include vessel access, catheter placement, any contrast injections, fluoroscopy, radiological supervision and interpretation, and arterial closure by pressure or device. Read on to learn details that will help you choose among the different code possibilities.

36221: Know the Non-Selective Option

The first new code is specific to non-selective catheter placement:

» 36221 — Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervico-cerebral arch, when performed.

Code 36221 applies only when the catheter goes as far as the thoracic aorta and no farther. Imaging of the aortic arch and origin of the great vessels is also included in this code, CPT® guidelines state.

Note that 36221 is the only code that specifies “unilateral or bilateral.” All of the others are unilateral. This makes sense because imaging from the thoracic aorta allows visualization of the aortic arch and origin of the great vessels.

(Continued on next page)
of both sides from that single catheter position. In contrast, the other codes require selective placement of the catheter in either a right-side or left-side vessel.

36222-36224: Choose the Most Comprehensive Service

The first three selective codes in the new range are 36222-36224. To choose the proper code, you must watch for where the catheter terminates (common carotid, innominate, internal carotid) and which vessels are imaged (extracranial carotid, intracranial carotid). Imaging of the cervicocerebral arch will not change your coding because all of the codes include that service when performed, says Graham.

» 36222 — Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

» 36223 — Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

» 36224 — Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed.

Guidelines instruct that these codes are hierarchical, so you may report only one code from 36222-36224 for each same-side carotid territory. In other words, if the physician places the catheter in the left common carotid and images the extracranial circulation and then places the catheter in the left internal carotid and images the intracranial circulation, you should report only 36224. You should not report 36222, as well. Code 36224 represents the most selective catheter placement and all of the angiography services performed.

36225-36226: Catheter Position Is the Key

The next two new codes are also hierarchical, only varying based on the placement of the catheter:

» 36225 — Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

» 36226 — Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.

As you might expect, you should report only one of these codes per same-side vertebral territory. Vertebral artery placement is more selective than subclavian or innominate. So you should report 36226 if the physician images the vertebral circulation from the subclavian or innominate in addition to from the vertebral artery.

+36227: Limit This Add-On to 3 Primary Codes

The first new add-on code in the series is +36227:

» +36227 — Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure).

CPT® guidelines state that this code includes artery access, catheter placement, contrast injection, fluoroscopy, and radiological supervision and interpretation. Add-on codes are designed to be reported in addition to primary procedure codes. In this case, you should report +36227 in addition to 36222, 36223, or 36224.

+36228: Don’t Take ‘Each Branch’ at Face Value

The final new code in the range is also an add-on code:

» +36228 — Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (e.g., middle cerebral artery; posterior inferior cerebellar artery) (List separately in addition to code for primary procedure).

The primary code options for this add-on code are 36224 and 36226.

Although the definition states “each intracranial branch,” you shouldn’t get carried away with units. Guidelines clarify that you should not report the code “more than twice per side regardless of the number of additional branches selectively catheterized.”

A single unit of the code includes the usual list of vessel access, catheter placement, contrast injection, fluoroscopy, and radiological supervision and interpretation. But for proper application of the code, you also need to understand that once you’ve coded catheter placement in a primary branch of the internal carotid, vertebral, or basilar artery, then any additional second or third order catheter placement in that branch is included in the code, too. ☑
‘Surgery Guidelines’ Designation Limits How You Use Codes

CPT® and Medicare rules agree.

When your surgeon uses a code that CPT® identifies with the words “separate procedure,” you better check your claim carefully to make sure you won’t face denials.

Look to CPT® for Definition

CPT® surgery guidelines define separate-procedure codes as services “that are commonly carried out as an integral component of a total service or procedure…” The designation restricts when and how you can report separate-procedure codes with any other related procedures, according to the guidelines.

For example: Under most circumstances, you shouldn’t report 44180 (Laparoscopy, surgical, enterolysis [freeing of intestinal adhesion] [separate procedure]) with other intestinal laparoscopy codes for the same patient on the same day.

Follow Medicare Guidelines, Too.

Medicare also gives clear instruction about when to use separate-procedure codes. According to Josie Dunn, CPC, at the University of Maryland Faculty Practices, Medicare states: “…the codes listed as ‘separate procedure’ should not be reported in addition to the code for the total procedure or service. In other words, report a separate procedure if it is not performed with a primary procedure that encompasses the ‘separate’ one, or when it adds ‘appreciably to the time and/or complexity of the procedure.’”

Medicare also states, “If a CPT® code descriptor includes the term ‘separate procedure,’ the CPT® code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a ‘separate procedure’ when performed with another procedure in an anatomically related region, often through the same skin incision, orifice, or surgical approach.”

Opportunity: You may report a CPT® code with the “separate procedure” designation with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area (often through a separate skin incision, orifice, or surgical approach).

Do this: Append modifier 59 (Distinct procedural service) or a more specific modifier (e.g., anatomic modifier) to the “separate procedure” CPT® code to indicate that it qualifies as a separately reportable service, says Heidi Stout, BA, CPC, COSC, PCS, CCS-P, Coder on Call, Inc., Milltown, New Jersey and director of orthopedic coding division, The Coding Network, LLC, Beverly Hills, CA.

Reader Questions

Learn Modifier PD Payment Impact

Question: Our surgery group practices in a freestanding facility not operated by a hospital. When a patient comes in to see one of our surgeons for an appointment and is admitted to a hospital within three days, do we need to use modifier PD?

Illinois Subscriber

Answer: If the entity you’re coding for is not wholly owned or operated by a hospital, then you don’t need to append modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days).

On the other hand, those entities (practices, etc.) that are wholly owned or operated by a hospital and that provide any diagnostic or related non-diagnostic services to a patient who is admitted to that hospital within three days must append modifier PD to the codes for those services. They must apply the modifier to relevant services as of July 1, 2012.

Practices self-designate during Medicare enrollment whether they’re owned or operated as a hospital. The hospital is

(Continued on next page)
responsible for alerting the practices they own or operate if the patient is admitted.

When practices append PD to a code that doesn’t have both professional and technical components, Medicare will pay for the service based on the facility rate (rather than the non-facility rate). If a code has both professional and technical components, modifier PD will trigger Medicare to pay the practice for only the professional component. The technical component will be considered a hospital cost.


Include Lesion Excision In Tissue Transfer

Question:
Our surgeon excised a carcinoma of the face. He closed the excision using adjacent tissue transfer. Can I report 14040 and 11643?

Tennessee Subscriber

Answer:
No. You should report 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq. cm or less) for the closure using existing tissue transfer.

In this case, you should report 14040 only. The lesion excision (11643, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm) is included in the tissue transfer.

Exception: There is one exception to this coding scenario. If your surgeon performed the excision on a separate (earlier) day from the tissue transfer, you may report the procedures separately. This may have occurred, for example, if the doctor wanted to wait for the pathology report to be sure the margins are clear before closing the operative wound.

Sticking point: However, if the tissue transfer occurred during the excision’s 10-day global period, you must append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the tissue transfer code (14040).

Avoid 62 with Unlisted Procedure

Question:
How should we bill for a laparoscopic excision and closure of a colovesical fistula with two surgeons? Our surgeon performed the bladder side of the procedure, excising bladder tissue due to localized necrosis, followed by two-layer closure. Our surgeon then instilled saline to check for evidence of leaks.

SuperCoder Subscriber

Answer:
Because there is not code for doing this procedure laparoscopically, you should report the service as 44238 (Unlisted laparoscopy procedure, intestine [except rectum]).

Although you indicate that the procedure involved two surgeons, you should not try to use modifier 62 (Two surgeons), because most payers don’t want pricing modifiers such as 62 on unlisted procedure codes.

Do this: Because you need to indicate the price for an unlisted code, you should price the procedure as though you used modifier 62. That means setting the value at 125 percent of 44661 (Closure of enterovesical fistula; with intestine and/or bladder resection) times 62.5 percent for your surgeon’s work on the bladder side.

Modifier 24 Makes E/M During Global a Possibility

Question:
When a patient is having feeding problems following major surgery, can the surgeon bill for hospital visits for the TPN even though it’s within the global period? If so, what CPT and ICD-9 codes should we report?

Texas Subscriber

Answer:
Under some circumstances, you may be able to separately charge for your surgeon’s patient visits related to total parenteral nutrition (TPN) for the patient with feeding difficulties. Not for complication: If the feeding difficulties are a complication of surgery, you can’t separately bill Medicare or some other payers.

However, if it’s not for a complication and you have good documentation, you should be able to bill your surgeon’s
additional services. Choose an appropriate E/M code such as 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient …)

You’ll need to report modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) with the E/M code.

Regarding the ICD-9 code, without more specific information, the best code appears to be 783.3 (Feeding difficulties and mismanagement).

Make Sure Surgical Approach Matches Code

Question:
How should we bill a laparoscopic pyloromyotomy? In general, if our surgeon performs a laparoscopic procedure that doesn’t have a specific code, should we use the open-code for the procedure?

Answer:
You should bill the laparoscopic pyloromyotomy as 43659 (Unlisted laparoscopic procedure, stomach). You should not use the open code for the procedure (43520, Fyloromyotomy, cutting of pyloric muscle [Fredet-Ramstedt type operation]).

General rule: You should never use a code for a surgical procedure if the approach doesn’t match. That is, don’t use an open code for a laparoscopic procedure, or vice versa. Instead, you should use the unlisted code that best describes the service.

You run into this situation as laparoscopic procedures become more common before new, specific laparoscopic codes are available.

Listen to payers: If you have payers that want you to bill differently to avoid using unlisted codes, you should follow their instruction — but get it in writing.

‘Buckle’ Equals Lap Band Revision

Question:
Our surgeons perform Gastric Lap Band for obesity. Lately we have had a couple of procedures where the only purpose is to either “unbuckle” the band or to “buckle” the band related to pouch dilation. These are done laparoscopically. I am at a loss on how to code this — is it a lap-band adjustment?

Answer:
The procedure you describe s not a lap-band adjustment, which involves loosening or tightening the gastric band via a needle in a port.

Instead, the procedure you describe involves a newer lap-band product that allows the surgeon to “unbuckle” the band in the event of repeat problems with pouch dilation. After releasing the band for a period of time, the surgeon can than “buckle” the band back.

The best code to report this service is 43771 (Laparoscopy, surgical, gastric restrictive procedure; revision of gastric restrictive device, component only). You would report the code once for the unbuckle procedure, and again for the buckle procedure at a later date.

Reader Questions and You Be the Coder were prepared with the assistance of Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, audit manager for CHAN Healthcare in Vancouver, Wash.
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