This month's column addresses—and reinforces—important concepts in coding for di erent types of surgical procedures using a series of ctional cases that cover the following areas: trauma, breast, vascular, gastrointestinal, and hand surgery.*

Trauma surgery

Case: A 30-year-old male involved in a motor vehicle collision arrives at the hospital in shock. He is taken to the operating room (OR), his spleen is removed, and a single segment of small bowel is resected. Damage control techniques leave the bowel disconnected. A temporary closure is applied. e following day, one of the surgeon's partners takes the patient back to the OR and removes additional bowel with a small bowel re-anastomosis and closes the abdomen. Reportable codes include the following:

Day 1:
38100, *Splenectoh* [to0h.uTw 8100, 44120–52, Enterectomy, resection of small intestine;*

negative in ltrating ductal carcinoma. A multi-gene assay showed the patient would bene t from adjuvant chemotherapy, so she undergoes insertion of a venous access port two weeks following lumpectomy. is falls within the 90-day global billing period following lumpectomy. Reportable codes include the following:

36561–58, Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 or older

77001, Fluoroscopic guidance for central venous access device placement, replacement

or

76937, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites

Insertion of a subcutaneous venous access port is reported with code 36561 and modi er 58 is appended because this is staged or related procedure performed by the same physician within the postoperative global period. A diagnosis of breast cancer (International Classi cation of Diseases, Ninth Revision, Clinical Modi cation [ICD-9] code 174.0-174.9) is reported.

If imaging guidance is required for port placement, this may be reported with code 77001 for uoroscopic guidance or 76937 for ultrasound guidance. Note that use of ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is used. Either the surgeon or the radiologist may report the guidance code.

Case: A 78-year-old female undergoes a left simple mastectomy and sentinel lymph node biopsy for extensive cuctal carcinoma in situ of the left breast. e evening of the surgery, the patient develops swelling, pain, and ecchymosis over the left chest wall with copious bloody drainage in the closed suction drain. Examination shows a post-mastectomy hematoma and the patient undergoes surgical evacuation of the hematoma in the operating room that night. Reportable codes:

35820–78, *Exploration for postoperative hemorrhage, thrombosis or infection; chest*

Evacuation of a hematoma of the chest is reported with code 35820 and modi er 78 is appended because this occurred during the global period of the mastectomy and was an unexpected return to the operating room.

Vascular surgery

Case: A 68-year-old male nursing home resident who has never been seen in the surgeon's o ce has a profound ischemic rest pain in the right lower extremity. Angiography demonstrates severe infrapopliteal trifurcation occlusive disease with reconstitution of the anterior tibial artery. He has preoperative vein mapping, which demonstrates adequate caliber saphenous vein. e surgeon decides to perform a distal bypass with reverse saphenous vein. Reportable codes include the following:

Day 1:

9920X, O ce or other outpatient visit for the evaluation and management of a new patient

Day 2:

36246, Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

75625, Aortography, abdominal, by serialography, radiological supervision and interpretation

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the level of service documented. At this visit the surgeon decides that he will require surgery and that vein mapping will be necessary. Vein mapping, performed that same day, is reported using the extremity vascular ultrasound codes which are typically divided into "unilateral or limited" or "complete and bilateral." Vein mapping does not typically involve evaluation of the deep system and, therefore, is classi ed as "limited." A unilateral or bilateral vein ultrasound that does not interrogate the deep system is also classi ed as "limited" and reported with code 93971. e next day, the surgeon performs a distal bypass with reverse saphenous vein, reported with code 35566.

Gastrointestinal surgery

Case: A 45-year-old patient is taken to the OR for a laparoscopic cholecystectomy; at the time of the procedure, the surgeon discovers an umbilical hernia. e surgeon extends the surgical excision in order to repair the umbilical hernia. e reportable code is:

47562, *Laparoscopy, surgical; cholecystectomy*

Only the laparoscopic cholecystectomy is reported. When a laparoscopic cholecystectomy is performed, by convention, the approach is always through the umbilical area. If there is a defect (for example, umbilical hernia), then it is repaired as part of the closure. ere is no additional coding for the repair of the umbilical hernia.

Hand surgery

Case: A patient with contracture of the right ring and small nger, metacarpophalangeal joints due to Dupuytren's disease, undergoes percutaneous needle aponeurotomy to release two cords. e reportable code is:

26040, Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous

Although two cords were released during this procedure, the Centers for Medicare & Medicaid Services has interpreted this code as applying to the release of one or more palmar cord.

Decision for surgery

Modi er 57 is appended to an E/M service to indicate the "decision for surgery." Whether the day before surgery or the day of surgery, the E/M service CPT code must have modi er 57 appended so that the service is not disallowed as part of the surgical package. Modi er 57 is usually used with major procedures (for example, those with a 90-day global period).

Case: A diabetic patient presents in the emergency department with acute cholecystitis. Options are discussed with the patient and the patient's primary care physician admits the patient for aggressive blood glucose control. You plan to perform a laparoscopic cholecystectomy. Proposed surgery is performed the following day. Reportable codes include the following:

Medicare patient:

9922X–57, Initial hospital care

47562, Laparoscopy, surgical; cholecystectomy

e initial E/M service is reported with an initial hospital inpatient code (99221-99223), selected based on the level of service documented. Modi er 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. Medicare does not recognize consult codes. It directs that all physicians use the initial inpatient or observation codes (depending on the admission status of the patient); the primary admitting physician appends the E/M codes with the modi er AI. e laparoscopic cholecystectomy is reported with code 47562; no modi er is appended. If a cholangiography is indicated, report code 47563, *Laparoscopy, surgical; cholecystectomy with cholangiography.*

Non-Medicare patient:

9925X–57, Inpatient consultation for a new or established patient

47562, Laparoscopy, surgical; cholecystectomy

e initial E/M service is reported with a consultation code (99251-99255), selected based on the level of service documented. Modi er 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. e laparoscopic cholecystectomy is reported with code 47562. No modi er is appended. If a cholangiography is indicated, report code 47563, *Laparoscopy, surgical; cholecystectomy with cholangiography.*

E/M on day of surgery

Modi er 25 is appended only to E/M codes, indicating that a "signi cant, separately identi able" E/M service is provided on the same day as a "minor"

procedure (for example, those with a 0-day or 10-day global period) per Medicare guidelines.

Case: A patient notes a lump in her right breast the day of her laparoscopic cholecystectomy. The surgeon evaluates the 2 cm periareolar right breast mass and determines that a biopsy is necessary. Reportable codes include the following:

9923X–25, Subsequent hospital care

19100, Biopsy of breast; percutaneous, needle core, not using imaging guidance

The E/M service for the evaluation of the right breast is unrelated to the cholecystectomy and is reported with a subsequent hospital E/M code (99231-99233), selected based on the level of service documented. Modifier 25 is appended indicating a significant, separately identifiable service. In this case, the ICD-9 code will be different (lump or mass in breast, 611.72). The breast biopsy procedure, reported with code 19100, does not take modifier 25.

Procedures in the postoperative global periods

Case: A 53-year-old woman has undergone a unilateral mastectomy. Ten days later, the surgical site remains open and unhealed. She returns to the office and a wound vac is placed.

For Medicare claims, the global surgical package includes treatment of all complications related to the surgery, unless there is a return to the operating room or procedure room (as defined by CMS). Thus, if the surgical site of a mastectomy patient becomes infected, requiring placement of a wound vac in the office, this procedure is not separately reportable, unless performed in a CMS-approved procedure room.

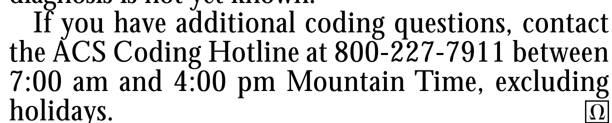
Some payors may use Medicare rules in this situation, but many do not. Thus, if a wound vac is placed in the office, for a non-Medicare patient, the reportable procedure is as follows:

97605–78, Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

Diagnosis coding

Is a lesion of uncertain diagnosis reported with ICD-9 code 238.2, *skin neoplasm of uncertain behavior?*

If a surgeon is unsure of a diagnosis, the ICD-9 code should not be selected until after the pathology report is complete. ICD-9 code 238.2 is a definitive diagnosis. A diagnosis of uncertain behavior may include lesions such as dysplastic nevi and congenital giant pigmented nevi. ICD-9 code 238.2 should not be used if the diagnosis is not yet known.


If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, excluding holidays. Ω

Editor's note

Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.

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