

AMBULATORY CODING AND PAYMENT REPORT

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Update:

Watch How You Sequence and Link Colonoscopy Dx

► **Don't be thrown by this wrinkle in 'screening-turned-diagnostic' coding**

Recent CMS instruction has ended confusion over how to diagnose a screening colonoscopy that turns diagnostic with polyp removal, but there remains one potential pitfall when you're preparing these claims. Get the complete facts here to avoid a crucial mistake.

List Screening V Code First ...

If a service for a Medicare beneficiary starts out as a screening examination, "then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination," says *Medicare Learning Network (MLN) Matters* article SE0746, "Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy."

Cite neoplasm as secondary: *MLN Matters* SE0746 further instructs that if the physician finds a neoplasm during a screening exam, you should "indicate the secondary diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.)."

Example: During a previously scheduled screening colonoscopy for a Medicare patient, the physician discovers several polyps, which he removes immediately by snare technique (for instance, 45385, *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s] or other lesion[s] by snare technique:* APC 0143).

In this case, because the service began as a screening, you would assign the screening V code as the primary (first-listed) diagnosis (for instance, V76.51, *Special screening for malignant neoplasms; intestine; colon*). You would then list an appropriate ICD-9 code on the second line to describe the neoplasms the physician removed (for example, 211.3, *Benign neoplasm of other parts of digestive system; colon*).

... but Link the Polyp Dx to CPT Code

Although you should list the screening diagnosis first on the claim form, your diagnosis pointer should nevertheless link the appropriate *polyp* diagnosis to the

diagnostic colonoscopy CPT code, says **Diane O'Brien**, a nearly 40-year veteran insurance coder and coordinator with Surgical Associates in Warner Robins, Ga.

CMS explicitly requires this coding. In an example of a screening-turned-diagnostic colonoscopy, *MLN Matters* SE0746 instructs you to enter a "2" in the diagnosis pointer (Item 24E on the CMS-1500 claim form), thus linking the CPT procedure code to the "line 2" diagnosis (that is, the polyp). Further language in the article clearly indicates that the "2" in Item 24E is "to link the procedure (polypectomy or biopsy) with the abnormal findings (polyp, etc.)."

Therefore, for our example above of a diagnostic colonoscopy (45385) that began as a screening, with a primary diagnosis of V76.51 and a secondary diagnosis of 211.3, you would enter V76.51 in box 21 (1) of the CMS-1500 claim form. In 21 (2), you would list 211.3. In item 24.1.d, enter 45385. Finally, place a "2" in box 24.1.G.

The CMS-1500 form is appropriate in the ASC and, for some payers, in a hospital outpatient setting. Medicare, however, requires hospital outpatient departments to bill using form UB-04 (CMS-1450). On this form, you would enter the procedure code on line 44, listing the principal diagnosis on line 67, with secondary diagnoses in the additional boxes 67a-q. CMS provides no special instructions for filing this form with a screening-turned-diagnostic colonoscopy.

Look Out for a Potential Problem

CMS' convoluted method of reporting diagnoses for screening-turned-diagnostic colonoscopies may not be compatible with all billing systems. As a result, some practices are finding themselves in a lurch — and searching for alternative solutions.

"Our computer system is not compatible with this format [of linking the procedure code to a secondary diagnosis]," O'Brien says. Therefore, the only way to "link the procedure (polypectomy or biopsy) with the abnormal findings (polyp, etc.)," as CMS instructs, is to list the polyp diagnosis as primary, she says.

Although she hasn't seen denials arising from this problem yet, O'Brien is concerned. "We are still working with our clearinghouse to resolve this issue," she says.

Best bet: If your billing system won't allow you to precisely follow CMS' instructions regarding diagnosis coding for a screening colonoscopy turned diagnostic, contact your payer immediately and ask for guidance on how to move forward.

Learn more: For additional information on screening-turned-diagnostic colonoscopies (including instructions on appropriate CPT coding for these services), as well as *MLN Matters* SE0746, see *Ambulatory Coding and Payment Report*, Vol. 13, No. 4, "CMS Stops Colonoscopy Confusion Cold." □

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New ABN Will Free You From NEMB Confusion

► **Update now if you're not already using the revised form**

If you never quite understood when you should provide a patient with an ABN rather than an NEMB for a noncovered service, CMS has just made your life easier.

Earlier this month, the agency unveiled its new advance beneficiary notice (ABN). This new form not only replaces the previous ABN-G (for physician services) but also incorporates the notice of exclusions from Medicare benefits (NEMB) form. CMS expects this new, combined form to “eliminate any widespread need for the NEMB in voluntary notification situations,” according to the new ABN Form Instructions document.

The old way: Previously, you would use an ABN only for procedures that Medicare might not cover. The ABN did *not* apply to procedures that CMS statutorily excluded from Medicare benefits — that’s where you would have used the NEMB instead.

The new way: Now, CMS will accept the new ABN form for either a “potentially noncovered” service or for a statutorily excluded service. “The revised version of the ABN may also be used to provide voluntary notification of financial liability,” CMS confirms.

Get ready for the change now: Medicare carriers began accepting the new ABN form as of March 3, but CMS has implemented a six-month transition period. Although you aren’t required to submit the new form until Sept. 1, you may find making the change immediately a little easier.

How to get it: You can view a sample copy of the revised ABN, as well as CMS’ complete instructions for implementing and using the form, on the CMS Web site www.cms.hhs.gov/BNI/02_ABNGABNL.asp.

Remember These 3 ABN Tips

Although the ABN form has changed, many of the previous ABN best practices remain (mostly) the same. Here are four guidelines to follow anytime you use the form.

1. Provide the ABN up-front. If you discover that a patient’s upcoming procedure is not payable by Medicare but the patient still wants you to perform the service, the ABN will inform the patient that he may be responsible for paying the noncovered portion.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay for it. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare refuses to pay. Without a valid ABN, you cannot hold a Medicare patient responsible for the denied charges, says **Kara Hawes, CPC-A**, with Advanced Professional Billing in Tulsa, Okla.

“The patient has to sign the ABN form at the time of service, otherwise the form is not valid,” Hawes says. “When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient.”

2. Explain the ABN to the patient. ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the procedure in question; 2) cancel the procedure; or 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure.

3. Give the patient an estimate. “Medicare is going to require that the estimated cost be included on the form starting in September. That’s a big change,” says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO**, manager of compliance education for the University of Washington Physicians and Children’s University Medical Group Compliance Program. You might as well adapt now, and save risking mistakes later on.

Apply Modifiers to Explain ABN Status

When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare’s explanation of benefits (EOB) will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

“You should use the GA modifier (*Waiver of liability statement on file*) when the service provider believes the service is not covered and the office has a signed ABN on file,” says **Dena Rumisek**, biller with Grand River Gastroenterology PC in Grand Rapids, Mich. This might include tests ordered without a payable diagnosis code or those ordered more frequently than covered.

Modifier GY (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit*) applies when Medicare excludes the service and you’re using the new ABN as you would have used the NEMB in the past.

(Continued on next page)

Modifier GZ (*Item or service expected to be denied as not reasonable and necessary*) means that you didn't issue an ABN when you probably should have, and you cannot bill the patient when Medicare denies the service. □

Ramp Up Your Revalidation Process — Now

► Medicare can pull your billing privileges for non-compliance

If you bill Medicare at your facility, you should be getting a strong handle on Medicare's "revalidation process," if you haven't already. Why? Because, if you're not in compliance, it's only a matter of time until your carrier or fiscal intermediary (FI) can pull the plug on your billing privileges.

Background: According to CMS ruling 42 CFR 424.515 in the April 21, 2006, *Federal Register*, all Medicare providers must revalidate their Medicare information on file, via a CMS-855 form, within 60 days of receiving a written revalidation request from their CMS fiscal intermediary or carrier, says **Lyndean Brick, JD**, senior vice president of Murer Consultants Inc. in Joliet, Ill.

That sounds simple enough, but many providers have never filed a complete CMS-855 — which can make the revalidation process quite difficult, Brick says. You may even receive an on-site survey if CMS discovers enough discrepancies.

But that's not all: "Generally speaking, once a provider submits a complete CMS-855, either in response to a revalidation request or otherwise, the provider must then revalidate his or her entire CMS-855 filing once every five years — or within 90 days after any change in his or her Medicare provider information," Brick says.

Know What CMS Wants

If you're not sure what kind of information you need to have lined up for CMS for revalidation, check out a copy of the Medicare enrollment form online at www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf. You'll notice that the agency requires a slew of information ranging from your practice name to your licensure status.

You may find that pieces of this required information are out of date for your practice or facility, and if that's the

case, you should fix that fast and submit a fresh 855 form to CMS.

Important: As you update your information, consider consistency a top priority.

"One of the biggest problem areas we find is that providers aren't consistent with names, among other things in their legal documentation," Brick says.

For example, an ASC may have opened with the name "Physicians Day Surgery," bills as "Physicians Surgical Center," yet its information on file with CMS may say "Physicians Outpatient Surgery Center." CMS won't go for that.

Critical: And now, with national provider identifier (NPI) requirements going into full-swing, the practice or facility name and other information you've filed on your NPI application must match your legal documentation. "Even if one little thing gets out of whack and CMS catches it, its contractors can stop reimbursement," Brick says, "even something as small as your IRS information not matching your NPI information."

Tip: See below for a list of questions you should be asking when you audit your information on file.

Keep an Eye on the Timing

The CMS revalidation process is being enforced over a five-year period that began last year, and the initial revalidation effort focused on Medicare contractors' top 100 billers. But that doesn't mean you should wait for your carrier or FI to contact you.

"CMS will continue to push its revalidation efforts with smaller healthcare organizations as the effort phases in," Brick says. And you're much better off being prepared with your most up-to-date information on-hand than to be scrambling to get your ducks in a row and risk having your billing privileges revoked.

You Be the Coder

How Can You Report Separate Removal, Biopsy?

Question: *A physician destroys an actinic keratotic lesion on a patient's left wrist using laser surgery, and then biopsies a mass on the patient's back. The biopsy report indicates that the lesion is benign. Can we report codes for the lesion destruction and the biopsy?*

Indiana Subscriber

Answer: See page 54. □

In a nutshell: Medicare providers have a lot of housecleaning to do in their legal documentation so they can turn in a clean and up-to-date 855 form. And from here on out, anytime you have even the slightest change in your legal information, even something as small as an address change, you need to notify Medicare of that change within 90 days.

Resources: To view the entire rule, see http://a257.g.akamaitech.net/7/257/2422/13nov20061500/edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr424.515.pdf □

Ask 11 Questions to Assess Revalidation Compliance

► *If your answer isn't 'yes' to these items, it's time to make changes*

1. Is the provider's Medicare correspondence address on file current and reliable? If not, the provider may not receive a revalidation request.
2. Does the provider have processes in place to track pertinent information on new and existing board members and managing employees?
3. Does the provider actively track all practice locations that are billed as provider-based?
4. Is the provider prepared to submit all required supporting documentation with a complete CMS-855, such as legal formation documents, IRS tax ID confirmations, state licenses, certifications, EFT bank account letters and NPI confirmations?
5. Do the provider's NPI(s) accurately reflect applicable provider numbers and taxonomy codes, legal business names, etc.?
6. When submitting a revalidation application, does the application accurately reflect all practice locations?
7. Are Section 5's included for all organizational owners and managers, including chain home offices?
8. Are Section 6's included for all board members and at least one W-2 managing employee?
9. Does the provider retain copies of all Medicare enrollment applications? These should include initial enrollments, changes of ownership, changes of information and revalidations.
10. Does the provider file CMS-855 changes of information within 90 days of all changes to practice locations, board members, managing employees, owners, authorized officials and delegated officials?

11. Does the provider have a CMS-issued provider-based determination for each practice location listed in the 855 (if applicable)?

Special thanks: List of questions provided by Murer Consultants Inc. □

READER QUESTIONS

Base Block Coding on Levels, not Nerves

Question: *Our surgeon documented that he administered a nerve block to the left side of C3 through C7. How many levels do we consider this when coding?*
Pennsylvania Subscriber

Answer: Base your coding on the facet joint level — rather than the individual nerves — the surgeon treats.

Facet joint nerves C3 and C4 innervate the C3-C4 facet joint. So you would report a nerve block to this joint with 64470 (*Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level*: APC 0207).

The C4 and C5 facet joint nerves innervate the C4-C5 facet joint, the C5 and C6 facet joint nerves innervate the C5-C6 facet joint, and the C6 and C7 facet joint nerves innervate the C6-C7 facet joint. Report blocks to each of these facet joints using +64472 (... *cervical or thoracic, each additional level [list separately in addition to code for primary procedure]*: APC 0206).

Your final claim should include 64470 once, plus three units of 64472.

□

Sort Out 2 Tympanoplasty Repairs

Question: *Is ossicular chain reconstruction the same as underlay temporal fascia graft (TFG)?*
Alabama Subscriber

Answer: No, these are two different procedures that reconstructive ear surgery may involve.

In ossicular chain reconstruction, the surgeon repairs a defect or eroded middle-ear bone using the patient's ossicles (tiny ear bones). You should not code this reconstruction separately, but with a tympanoplasty-with-mastoidectomy code that includes an ossicular chain reconstruction component.

(Continued on next page)

Tympanoplasty with mastoidectomy with ossicular reconstruction falls under three codes:

- 69642 — *Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction: APC 0256*
- 69644 — *... with intact or reconstructed canal wall, with ossicular chain reconstruction: APC 0256*
- 69646 — *... radical or complete, with ossicular chain reconstruction: APC 0256.*

The physician may harvest temporalis fascia, a sheet of fibrous tissue that covers the temporal muscle in the jaw, to repair an ear perforation. Because a temporal fascia graft

You Be the Coder

How Can You Report Separate Removal, Biopsy?

Answer: You can claim both the destruction and biopsy in this scenario, but you'll need the proper modifier and ICD-9 codes to prove the services' separate nature.

Typically, the Correct Coding Initiative (CCI) bundles lesion destruction and biopsy when a physician performs them on the same patient during the same encounter. You can unbundle the procedures, however, when the physician treats different body areas, as in this scenario (back and wrist).

On the claim, report the following:

- 17000 (*Destruction [e.g., laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesions [e.g., actinic keratoses]; first lesion: APC 0013*) for lesion destruction
- 11100 (*Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion: APC 0013*) for the biopsy
- Modifier 59 (*Distinct procedural service*) linked to 11100 to show that the biopsy and destruction were separate services.

Diagnosis coding is vital: To prove that the two procedures were for separate body areas, your diagnosis codes must show the exact locations of the lesion and the mass. On the claim, include the following diagnoses:

- 702.0 (*Actinic keratosis*) linked to 17000 to represent the lesion
- 216.5 (*Benign neoplasm of skin; trunk*) linked to 11100 if the back biopsy reveals a benign lesion. □

includes tissue only, the corresponding code is 20926 (*Tissue grafts, other [e.g., paratenon, fat, dermis]: APC 0135*).

Tympanoplasty-with-mastoidectomy codes 69642-69646 include a graft from the same site. If the graft involves a separate site, you may separately report the graft.

Insurers may now subject 20926 to a multiple procedure reduction. CPT 2008 eliminated the code's modifier 51 (*Multiple procedures*) exempt status.

Be Precise for Pain Dx

Question: *I often see physicians document "chronic pain" as a diagnosis. This seems rather imprecise to me. Is there a better choice than the 338.xx series codes for this condition?*

Indiana Subscriber

Answer: The ICD-9 manual's alphabetic index offers a fairly long and inclusive list of pain diagnoses, including a code for generalized pain (780.96), added in 2003, and the 338.xx series describing various chronic and acute pain conditions, added in 2007. These include the following:

- 338.0 — *Central pain syndrome*
- 338.18 — *Other acute postoperative pain*
- 338.19 — *Other acute pain*
- 338.21 — *Chronic pain due to trauma*
- 338.28 — *Other chronic postoperative pain*
- 338.29 — *Other chronic pain*
- 338.3 — *Neoplasm-related pain (acute) (chronic)*
- 338.4 — *Chronic pain syndrome.*

As you suspect, however, these pain codes aren't the most specific diagnoses available in most cases. In fact, Medicare guidelines state that you should assign a code from the 338.1x or 338.2x series only if the doctor hasn't yet made a definitive diagnosis. If the physician has already made a definitive diagnosis, you should list that first and the pain diagnosis second, if at all.

In addition, you should use 338.4 only when your patient actually has "chronic pain syndrome," according to CMS guidelines. "This condition is different than the term 'chronic pain,' and therefore this code should only be used when the provider has specifically documented this condition," it says.

The descriptor for 338.4 specifies that pain should be "associated with significant psychosocial dysfunction," which further limits the code's use.

Take a different approach: Rather than cite an imprecise pain diagnosis, you should ask the physician to pinpoint the pain's location and code accordingly.

For example, a patient with back pain might describe the discomfort as arising from the lower back (724.2), coccyx (724.79) or thoracic region (724.1). Remember: Always code to the highest level of specificity that the physician can determine accurately. Doing so will allow for better patient care and ease claims' payment.

Depth and Location Matter Most for Lipomas

Question: *Recently, our surgeon excised 18 lipomas from a patient's right arm, and 14 from his left arm (32 total). How should I report this? Will I need modifiers?*
Florida Subscriber

Answer: If you are certain that you are dealing with lipomas (non-cancerous fatty tumors), you should look to codes in CPT's musculoskeletal section, rather than to lesion excision codes (a lipoma usually occurs in subcutaneous tissue, rather than on the skin).

Your question doesn't specify the lipomas' precise location, but for upper arms the best codes are 24075 (*Excision, tumor; soft tissue of upper arm or elbow area; subcutaneous*: APC 0021) or 24076 (... *deep [subfascial or intramuscular]*: APC 0022), depending on the depth of the excision.

For the forearm area, use 25075 (*Excision, tumor; soft tissue of forearm and/or wrist area; subcutaneous*: APC 0021) and 25076 (... *deep [subfascial or intramuscular]*: APC 0022).

Remember: The lipomas' size is not an issue in coding, only the depth.

You should select the appropriate code for each lipoma the surgeon excises. To keep better track of the many lipomas the surgeon removes in this case, you may want to determine codes for one arm at a time, then add the total code units together at the end.

You may find that you're using more than one code. For instance, on the right arm, you may have 12 lipomas at superficial depth on the upper arm, two lipomas at superficial depth on the lower arm, and two more deep lipomas. So you would have 12 units of 24075, two units of 25075, and two units of 25076 (for a total of 16 units).

You would then code each removal on the left arm and add those totals to the totals from the right arm to determine the final units for each code.

You will want to report modifier 59 (*Distinct procedural service*) for any additional removals beyond the first at the same location. So using the above example of the right arm only, you should report 24075, then 24075-59 x 11; 25075 and 25075-59; 25076 and 25076-59.

Note that 32 is an extraordinary number of excisions for one session. Generally, you won't include an op report on the first submission due to electronic filing, but make sure you have documentation on hand in case the payer rejects the claim. You should be able to support your coding on appeal, if necessary.

Report a Single Code for Pressure Ulcer Treatment

Question: *The surgeon saw a patient to treat a pressure ulcer on her lower back. The physician removed devitalized tissue from the ulcer using a waterjet and forceps. The surface area of the wound was 13 sq cm. Can we report a code for the waterjet in addition to the debridement code?*

Montana Subscriber

Answer: No, you cannot report the waterjet separately because the debridement codes include the waterjet use.

On the claim, you should report the following:

- the appropriate code from the 11040-11044 series (*Debridement ... APCs 0015, 0016 and 0682*), depending on the documented depth of the debridement
- 707.03 (*Decubitus ulcer; lower back*) linked to the debridement code for the pressure ulcer.

You may be tempted to report 97597 (*Removal of devitalized tissue from wound[s], selective debridement, without anesthesia [e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], with or without topical application[s], wound assessment, and instruction[s] for ongoing care, may include use of a whirlpool, per session; total wound[s] surface area less than or equal to 20 square centimeters*: APC 0015) for the debridement, but CPT designed this code primarily for nonphysician practitioners.

Although physicians may use 97597, they would usually call on the skin debridement codes (11040-11044), particularly if an anesthetic is involved. Moreover, payers generally recognize and reimburse debridement codes more consistently in the physician setting.

Follow the Laser to Find the TURP Code

Question: *What is the most appropriate code to report when the urologist documents "green-light TURP"?*

North Carolina Subscriber

Answer: You should use 52648 (*Laser vaporization of prostate, including control of postoperative bleeding*,

(Continued on next page)

complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed]: APC 0429) for the green-light TURP procedure.

In most cases, the diagnosis code you'll report for the procedure will be 600.01 (*Hypertrophy [benign] of prostate with urinary obstruction*). Various payers may accept additional diagnoses, such as 222.2 (*Benign neoplasm of prostate*), 600.11 (*Nodular prostate with urinary obstruction*) and additional 600.xx diagnoses. Ask your individual payer for a list of allowable indications.

Remember: You must always choose a diagnosis based on the available documentation rather than automatically selecting the diagnosis that will get you paid.



Consider More Than Layers When Reporting Wound Repair

Question: Which is the appropriate code to report repair of an irregular, 5-cm laceration on the forehead involving subcutaneous tissue and muscle?

Tennessee Subscriber

Answer: From your description, this sounds like an intermediate-level wound repair, for which you should report 12052 (*Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.6 cm to 5.0 cm*: APC 0134).

During an intermediate repair, the surgeon usually closes one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin closure, according to CPT instructions.

Keep in mind: Layers alone do not determine the level of wound repair. You may also choose an intermediate repair code if the procedure involves extensive cleaning and debris removal, even if the closure involves only a single skin layer.

A complex repair, however, requires more than just a multi-layer closure. If you wish to report complex repair codes (13100-13160), the documentation should state that the surgeon corrected a defect or performed extensive tissue debridement.

— Reader Questions and You Be the Coder reviewed by **Sarah L. Goodman, MBA, CPC-H, CCP**, president of SLG Inc. in Raleigh, N.C. □

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