

GENERAL SURGERY CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in general surgery practices

2009, Vol. 11, No. 5 (Pages 33-40)

What's Inside

Learn When You Can Override CCI Edits, Legitimately35
▶ *Get reimbursement for bundled codes in 3 simple steps.*

Clip and Save:
Here's Your Handy Guide to the 15.0 CCI Edits.....36
▶ *Save this useful list to help troubleshoot when you're dealing with these changes.*

Case Study:
Mind Your Modifiers When Your Surgeon Works With Others37
▶ *Automatically appending modifier 52 could be costing you hundreds.*

You Be the Coder37
• Hospital Discharge After Consultation

Reader Questions

Differentiate Ileostomy From Feeding Tube39
Avoid Losing \$20 Per Excision39

CCI 15.0 Update:

Ease the Burden of the Latest CCI Edits By Mastering 4 Points

▶ **Good news: Edits shouldn't take a serious toll on your reimbursement bottom line.**

The Correct Coding Initiative (CCI), version 15.0, sets its sights on the new 2009 codes rather than adding many new edits for your established codes. Checking the modifier indicator one key to navigating the new edits. Read on for more tips.

New Lap Hernia Repair Codes Mean New Bundles

You've learned to expect that new CPT codes bring new bundles from CCI. The laparoscopic hernia repair codes are no exception. CCI 15.0 bundles a slew of codes into 49652 (*Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia [includes mesh insertion, when performed]; reducible*), 49653 (*...incarcerated or strangulated*), 49654 (*Laparoscopy, surgical, repair, incisional hernia [includes mesh insertion, when performed]; reducible*), 49655 (*...incarcerated or strangulated*), 49656 (*Laparoscopy, surgical, repair, recurrent incisional hernia [includes mesh insertion, when performed]; reducible*), and 49657 (*...incarcerated or strangulated*).

CCI bundles the six new lap hernia repair codes with 36000 (*Introduction of needle or intracatheter, vein*), 36410 (*Venipuncture, age 3 years or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for routine venipuncture]*), and 37202 (*Transcatheter therapy, infusion other than for thrombolysis, any type [e.g., spasmolytic, vasoconstrictive]*). All of these bundles have a modifier indicator of "1," meaning that you can override these edits with a modifier under the proper circumstances.

The new bundles between 49652-49657 and 43653 (laparoscopic gastrostomy), 44180 (laparoscopic enterolysis), 49320 (diagnostic laparoscopy), 49560 (initial hernia repair), 49565 (recurrent hernia repair), 58660 (laparoscopic lysis of adhesions), and 69990 (microsurgical techniques) all have a modifier indicator of "0," however. A "0" indicator means that you may not unbundle the edit combination under any circumstances, according to CCI guidelines. (See the chart on page 36 for additional bundles for the new laparoscopic hernia repair codes.)

Silver lining: The laparoscopic hernia repair bundles are "pretty intuitive," says **Charlotte T. Tweed, RHIA, CPC**, inpatient coder in the department of medical

education/coding at Florida Hospital in Orlando. “I don’t think a surgery coder would have much trouble with any of these edits.” Tweed says the edits mirror these standard coding guidelines:

1. As with most laparoscopic procedures, you wouldn’t report both a laparoscopic code and an open code.
2. You would not code repairs of approaches as you come back out.
3. Coding rules routinely include lysis of adhesions with other procedures, and you should not code them separately unless there are extensive problems requiring significant extra time.
4. You would not use the mesh code (49568) with the lap hernia codes because they specifically state mesh is included with that code. Reporting 49568 would be double billing for the mesh, Tweed explains.

In addition: You’ll also now find that the not-so-new laparoscopic repair codes for inguinal hernias (49650, *Laparoscopy, surgical; repair initial inguinal hernia* and 49651, ... *repair recurrent inguinal hernia*) face new edits this quarter. CCI now bundles both codes with 49650 and 49651 with 58660 (*Laparoscopy, surgical; with lysis of adhesions [salpingolysis, ovariolysis] [separate procedure]*) with a modifier indicator of “0.”

Edits Target Hemorrhoid Destruction Code, Too

CCI also hits the new hemorrhoid destruction code 46930 (*Destruction of internal hemorrhoid[s] by thermal energy [eg, infrared coagulation, cautery, radiofrequency]*) several bundling edits. You won’t be able to report 46930 with anesthesia code 00902, manipulation codes 45900-45915, anorectal exam code 45990, and more. You’ll be able to use a modifier to break some of the new 46930 bundles — for example, the bundle with nerve block codes 64415-64417 and new therapeutic, prophylactic, and diagnostic administration codes 96360-96375. (See the chart on page 36 for more details.)

“We were hoping the new hemorrhoid destruction code wouldn’t be bundled into a lot of other codes,” says **Heather Corcoran**, coding manager for CGH Billing in Louisville, Ky. “This is unfortunate but shouldn’t take too much reimbursement away from us.”

Avoid Overusing Modifier 59

Many of the new code edits have a modifier indicator of “1.” This means that you can unbundle these edits with the proper modifier under the appropriate clinical circumstances.

Although you can bypass many of the bundles with modifier 59 (*Distinct procedural service*), you must meet the criteria for doing so, says **Debra Pierce, MD, MBA**,

CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to general surgery coding, reimbursement and/or compliance to Leesa A. Israel, CPC, CUC, CMBS, at leesai@elijournals.com.

Mail: PO Box 413006, Naples, FL 34101-3006

Phone: (800) 508-2582 **Fax:** (800) 508-2592

Editor: Leesa A. Israel, CPC, CPC-URO, CMBS (leesai@elijournals.com)

Clinical and Coding Consults:

M. Trayser Dunaway, MD
Marcella Bucknam, CPC, CCS-P, CPC-H, CCA

Managing Editor: Mary Compton, PhD, CPC (maryc@eliresearch.com)

Associate Publisher: Jeanne Caggiano (jeannec@eliresearch.com)

Director of Development: Bridgett Hurley, JD, MA (bhg@eliresearch.com)

President: Samantha Gardiner Saldukas (sam@medville.com)

Director of Sales: Bill Streight (bills@medville.com)

Medallion Group Manager: Aleshia Elismond (aleshia@medville.com)

Live Conference Manager: Lucy Keith (lacyk@medville.com)

Audioconference Director: Jeanne Horne (jeanneh@eliresearch.com)

General Surgery Coding Alert (ISSN 1526-0356) (USPS # 019-299) is published monthly by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713.

© 2009 The Coding Institute. All rights reserved. Subscription price is \$397.

Periodicals postage is paid at Durham, NC, 27705 and additional entry offices.

POSTMASTER: Send address changes to *General Surgery Coding Alert* PO Box 413006, Naples, FL 34101-3006.

Web: www.codinginstitute.com **Customer Service:** service@medville.com **Discussion Group:** www.coding911.com

Rates: USA: 1 year. \$397; 2 yrs. \$774 (save \$20); 3 yrs. \$1141 (save \$50). Bulk prices available upon request.
Credit Cards Accepted: Visa, MasterCard, American Express, Discover.

CPT codes, descriptions and material only are copyright 2009 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS Restrictions Apply to Government Use.

General Surgery Coding Alert is independent and not affiliated with any organization, HMO, vendor or company. Reasonable attempts have been made to provide accuracy in the content. Of necessity, however, examples cited and advice given in a national periodical such as this must be general in nature and may not apply to any particular case. Further, medical coding is part science, part art; even experts sometimes differ. Also, clinical and other circumstances may differ between cases and thereby affect coding. Thus, neither the publisher, editors, board members, contributors nor consultants warrant or guarantee the information contained herein on coding or compliance will be applicable or appropriate in any particular situation. For information tailored to your specific circumstances, consult a qualified professional.

Have information on copyright violations? Call us! We'll share with you 25% of the net proceeds of all awards related to copyright infringement that you bring to our attention. Direct your confidential inquiry to Samantha Saldukas, phone 239-280-2301 or sam@medville.com

This publication has the prior approval of the American Academy of Professional Coders for 0.5 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the content. Call The Coding Institute at (800) 508-2582 for more information about how to receive your CEUs.



The Coding Institute also publishes the following newsletters. Call (800) 508-2582 for free samples:

Coding Monthlies:
Anesthesia & Pain Management
Cardiology
Emergency Medicine
Family Practice
Gastroenterology
Internal Medicine

Neurology
Neurosurgery
Ob-Gyn
Oncology & Hematology
Ophthalmology
Optometry
Orthopedics

Otolaryngology
Pathology/Lab
Pediatrics
Physical Medicine & Rehab
Pulmonology
Radiology
Urology

Other Newsletters:
Medical Office Billing & Collections Alert
Medical Office Front Desk Pro
Part B Insider

CPC, founder and managing member of Pierce MD Consulting LLC in Rockbridge, Ohio. CPT 2008 revised the modifier's descriptor, specifying, "Documentation must support:

- different session
- different procedure or surgery
- different site or organ system
- separate incision or excision
- separate lesion
- separate injury (or area of injury in extensive injuries)."

Caution: "CMS has improper use of modifier 59 on its radar screen and practices are well-advised to exercise due caution in using this modifier," Pierce cautions.

Remember: Although you can bypass many of the bundles using modifier 59, this is the modifier of last resort. CPT warns that you should not use modifier 59 "when another already established modifier is appropriate, unless no more descriptive modifier is available, and so long as it best explains the circumstances," Pierce says.

New Drug Admin Code Bundles Bring Mixed News

CCI bundles the new revised therapeutic, prophylactic, and diagnostic administration CPT codes 96360 (*Intravenous infusion, hydration; initial, 31 minutes to one hour*), 96365 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour*), 96372-96375 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug] ...*) into most of the surgical procedures your surgeon might perform, including 10040-10180 (incision and drainage) and 49652-49657.

Good news: The modifier indicator for all of these new bundles is "1," meaning that you can override these edits with a modifier under the proper circumstances. (For more on overriding CCI bundling edits, see "Learn When You Can Legitimately Override CCI Edits" on the right.)

Same bundles, different codes: The 2009 therapeutic, prophylactic, and diagnostic administration codes replaced the 2008 CPT intravenous and injection codes 90760, 90765, 90772, 90774, and 90775. The CCI 15.0 bundles for the new codes mirror the same bundles that CCI placed on the old 2008 drug administration codes

Plus: You'll also be out of luck if you try to report conscious sedation codes 99143-99144 (*Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician*

performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status ...) with any of the codes from the 49440-49442 series (tube placement). Medicare payers will deny the conscious sedation charge, and no modifier can separate the bundles.

"With each edition of CCI comes more codes that are forbidden to report with conscious sedation," says **Aran Hicks**, billing consultant for six practices in Raleigh, N.C.

Want to learn more? To download a free copy of CCI 15.0 go online to www.cms.hhs.gov/NationalCorrect-CodInitEd/NCCIEP/list.asp. □

Learn When You Can Override CCI Edits, Legitimately

► **Get reimbursement for bundled codes in 3 simple steps.**

There are times when you can override Correct Coding Initiative (CCI) edits and achieve separate reimbursement for bundled codes. Follow these steps if you have distinct services:

1. Check the modifier indicator. Each CCI code pair edit includes a correct coding modifier indicator of "0" or "1." A "0" indicator means that you may not unbundle the edit combination under any circumstances, according to CCI guidelines. But an indicator of "1" means that you may use a modifier to override the edit if the procedures are separate and distinct from one another.

2. Verify that the procedures are independent and distinct. You should attempt to override CCI code pair edits only if the paired procedures are separate and unrelated. For instance, the provider may have provided the services/procedures at different sessions, at different anatomic locations, or for different diagnoses.

3. Append modifier 59. You must append modifier 59 (*Distinct procedural service*) or another appropriate modifier to the column 2 code to indicate to the payer that the billed procedures are distinct and separately identifiable. Without modifier 59 or another appropriate modifier, the payer will simply apply the CCI edits and deny payment. □

Clip and Save:

Here's Your Handy Guide to the 15.0 CCI Edits

► **Save this useful list to help troubleshoot when you're dealing with these changes.**

If you get confused and frustrated sorting through all the lines of edits in the Correct Coding Initiative (CCI) files, refer to this easy-to-decipher chart to know what new code pairs you may separate with a modifier, and what codes carriers will never pay for. Note: The code in the left column (column 1) represents the comprehensive code. The bundled codes are in column 2, and the modifier indicator is in column 3. □

Additions

Column 1	Column 2	Mod. Ind.
49650, 49651	58660	0
49650, 49651	96360-96375	1
49652, 49653, 49654, 49655, 49656, 49657	36000, 36410, 37202	1
49652, 49653, 49654, 49655, 49656, 49657	43653, 44180, 49320, 49560, 49565, 58660, 69990	0
49652, 49653	49570, 49572, 49580, 49582, 49585, 49587, 49590	0
49652, 49653, 49654, 49655, 49656, 49657	50715, 51701, 51702, 51703	1
49652, 49653, 49654, 49655, 49656, 49657	62318, 62319, 64415, 64416, 64417, 64450, 64470, 64475, 96360, 96365, 96372, 96374, 96375	1
49653, 49655, 49657	49561, 49666	0
49652, 49653, 49654, 49655, 49656, 49657	49568	1
46930	00902, 45900, 45905, 45910, 45915, 45990, 46040, 46080, 46211, 46220, 46600, 46940, 46942, 69990	0
46930	36000, 36410, 37202, 45380, 51701, 51702, 51703, 62318, 62319, 64415, 64416, 64417, 64450, 64470, 64475, 96360, 96365, 96372, 96374, 96375	1

Deletions

Column 1	Column 2	Mod. Ind.
46935, 46936	46260	0
46947	46934, 46935, 46936	0
46934, 46935, 46936	00902, 45900, 45905, 45910, 45915, 45990, 46040, 46080, 46210, 46211, 46220, 46600, 46940, 46942, 69990	0
46934, 46935, 46936	36000, 36410, 37202, 45380, 51701, 51702, 51703, 62318, 62319, 64415, 64416, 64417, 64450, 64470, 64475, 90760, 90765, 90772, 90774, 90775	1

Case Study:

Mind Your Modifiers When Your Surgeon Works With Others

► **Automatically appending modifier 52 could be costing you hundreds.**

When your surgeon works with another physician during a procedure, you can face major coding challenges. If you don't coordinate your coding with the other physician's coder, both doctors could lose money and face audits.

Learn how to correctly code for these shared procedures with this real-world case study.

Review the Surgical Case

Scenario: A urologist and a general surgeon performed surgery on a patient. The urologist did the orchiopexy and performed the opening and closing. The general surgeon performed an inguinal hernia repair.

Coding dilemma: Which codes should each physician report, and what modifiers should the coders use, asks **Betsie Wilson, CPC**, professional fee coordinator and charge capture surgery team lead at University of Washington Physicians in Seattle, who presented this case study.

No Bundle Means Two Codes

CPT and the Correct Coding Initiative (CCI) do not bundle the two procedures together. In fact, if your general surgeon performed both the hernia repair and the orchiopexy without another physician, you would report both procedure codes.

For this case study, each physician will report his portion of the procedure. You will report the appropriate inguinal hernia repair code — such as 49500 (*Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible*) or 49505 (*Repair initial inguinal hernia, age 5 years or older; reducible*). The urologist's coder will report the applicable orchiopexy code (54640, *Orchiopexy, inguinal approach, with or without hernia repair*).

Expert Opinions Diverge on Modifier 52

As for deciding whether to attach modifier 52 (*Reduced services*) for your general surgeon in this case,

you'll need to talk with the physician and review his documentation.

Some experts say that opening and closing are such a small portion of a procedure that you should not append modifier 52 because the reduction in reimbursement would not be equal to the amount of time and effort the open/closing normally takes. Some coders, however, feel that reporting the code without a modifier isn't correct coding either.

"I personally don't add the 52 because the opening and closing are such a minor portion of the procedure that I don't consider the procedure 'reduced,'" says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor at the State University of New York, Stony Brook.

"We have had several cases lately with other surgeons, and I have never thought to append modifier 52 because we didn't open and/or close," says **Karla D. Garcia, CPC**, coder for Dr. West and Dr. Mayo in Paducah, Ky.

Downside: If your payer reduces every case by a third of the regular fee because you append modifier 52 even when your surgeon completes the entire procedure but not the open/close tasks, your practice could be losing hundreds of dollars over the course of a year.

Alternative: Some coders disagree, and say that a surgeon would use modifier 52 in a co-surgery situation where another surgeon performing a separate procedure opened and closed the patient. The rationale is that the first surgeon bills for the procedure with modifier 52 attached, to indicate that the procedure was performed without opening and closing.

"If your surgeon did not open or close the patient, you would report your coding with a modifier 52," says **Betsy**

(Continued on next page)

You Be the Coder

Hospital Discharge After Consultation

Question: *A family practice physician admitted a patient for treatment of severe abdominal pain, and then consulted with my general surgeon, who follows the patient through the episode of care. Both physicians want to report the hospital discharge. Can they split the discharge billing? If not, who should report it?*

Kansas Subscriber

Answer: See page 38. □

You Be the Coder

Hospital Discharge After Consultation

Answer: It sounds as if the family practice physician is the admitting “attending” physician. Therefore, the attending physician is the physician who reports the discharge code (99238-99239, *Hospital discharge day management ...*). According to CPT, under instructions for Hospital Discharge Services, “To report concurrent care services provided by a physician(s) other than the attending physician, use subsequent hospital care codes 99231-99233.”

Remember: Medicare and many other payers allow only the admitting physician to bill a discharge for the patient. However, if another physician in the same practice performs the discharge service — for example, if the admitting doctor is not available at the time of discharge — you can still bill for it. When physicians are all members of the same group, any of them can perform the discharge. For example, in a teaching setting, a resident, fellow, or physician extender of the group often performs the discharge.

However, if your surgeon performed a surgical procedure for the abdominal pain (for example, 44960, *Appendectomy; for ruptured appendix with abscess or generalized peritonitis*), any subsequent hospital care and discharge services would be part of the postoperative global surgical period, and there would be no charge for subsequent hospital care or discharge services within the global surgical period.

The problem: This question speaks to a problem that is an unfortunately common occurrence, experts say. A family physician admits a patient and consults the surgeon. The surgeon then actively manages the day-to-day care for the patient, and the family physician writes notes that basically concur with the surgical management. The patient does not undergo a surgical procedure. In the meantime, the family physician gets paid daily, while the surgeon gets a single consultation fee and no follow-up fees. And then upon discharge the family physician to report that service, too, even if the surgeon writes all the follow-up discharge orders. In these situations, the patient should be transferred to the surgeon so that you can accurately code the services your physician provides and be properly reimbursed. □

Donnelly, CPC, PCS, multi-specialty coder at Martin Memorial Health Systems in Stuart, Fla. “For instance, while an ob-gyn is doing an open procedure, he notices a mass within the intestine and calls in a general surgeon. If the general surgeon does a colectomy, you would code the appropriate colectomy code with a mod 52.”

Bottom line: You should use your best judgment based on the operative report and the rules your payer sets up for modifier 52.

Pitfall: Don’t append modifier 53 (*Discontinued procedure*) because your surgeon didn’t open or close. You look at modifier 52 when the physician completed what he or she set out to do but did so performing less than the complete procedure.

Use modifier 52, not 53, when the physician completed the surgery, but to a lesser extent than the code describes, Garcia says. “For me, the key phrase is ‘accomplished some result.’”

“An incomplete or cancelled procedure would use modifier 53, not modifier 52,” agrees **Laureen Jandroep, OTR, CPC, CPC-H, CPCEMS**, coding analyst for CodeRyte, Inc. and senior instructor for codingcertification.org.

Prepare to submit documentation: When submitting claims with modifier 52 attached, that you bill the procedure out at the full fee and include a cover letter that explains what wasn’t done and why.

“Don’t reduce your fee or else the payer may reduce your reduction,” Jandroep cautions. “Modifier 52 is one of those modifiers that will require documentation due to the varied circumstances. It is not a modifier that triggers a mathematical formula to be applied. Try to compare to a similar procedure represented by another CPT code that could help the payer price the reduced procedure accordingly,” she suggests.

Skip Modifiers 62 and 80

You should not use modifier 62 (*Two surgeons*) or modifier 80 (*Assistant surgeon*) in this case.

You would only report cosurgeons (using modifier 62) if the surgeons worked together on the *same* procedure and both are reporting the same CPT code, Ferragamo explains. In this case, each physician has his own procedure to report.

Example: Your general surgeon and another surgeon work together to perform a two-physician percutaneous gastrostomy (PEG) tube placement (43246, *Upper gastrointestinal endoscopy including esophagus, stomach,*

and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube). You and the other surgeon's coder would both report 43246-62.

Modifier 80 is not appropriate for this case study either, however. Technically, the surgeons are not assisting one another. Assisting is usually when they are both working together on a procedure (or procedures).

How it works: "If the surgeon is working on the hernia while the urologist is working on the orchiopexy, they are not assisting each other," Garcia explains. "They are not sharing equal work and responsibility for one procedure. Since they are both performing their own distinct procedure, you would bill your surgery alone, with no modifier." □

READER QUESTIONS

Differentiate Ileostomy From Feeding Tube

Question: *What is the difference between a tube and non-tube ileostomy? When can we charge for an ileostomy? The doctor did a laparoscopic colectomy and states, "I decided on a diverting ileostomy to protect the anastomosis." Is this the time to add the ileostomy?*

Connecticut Subscriber

Answer: You should avoid using the term "tube ileostomy" all together. An ileostomy is when a loop of ileum is brought up to skin level and opened to divert the fecal stream. Alternatively, a surgeon may insert a feeding tube into the jejunum, or more rarely the ileum, for post-op feeding. While technically this is an ileostomy, (a hole in the ileum), this is not clinically referred to as an ileostomy.

The description your surgeon provided sounds like a standard diverting ileostomy. Look at code 44187 (*Laparoscopy, surgical; ileostomy or jejunostomy, non-tube*) in addition to the colectomy code you report. CPT bundles the ileostomy with total colectomy (such as 44150, *Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy*), but not with a partial (such as 44140, *Colectomy, partial; with anastomosis*). Therefore, if the surgeon performed a partial colectomy, you can report both and 44187.

□

Avoid Losing \$20 Per Excision

Question: *I just received a pathology report back that reads: "The largest segment measures 3.5 x 3.5 x 2.0 cm. A second fragment measures 3.0 x 3.0 x 3.0 cm and then in aggregate, the smaller fragments measure 3.5 x 3.0 x 2.0cm." The surgeon excised these lesions from the patient's back and neck. How should I code this?*

Missouri Subscriber

Answer: You cannot code this excision solely from the pathology report. You need to go back to the physician's record of the procedure. You should select the appropriate lesion excision size code based on the physician's report.

Once the specimen is put in the jar and sent to pathology, the specimen shrinks down, sometimes to half its original size. CPT's excision sizes, including margins, are based on the physician's measurements at the time of the excision. Your surgeon should always measure an excision and document it with a statement, such as, "I'm going to excise this X cm length by X width lesion. I took 4 cm margins."

Reminder: If documentation indicates the margin is applicable to both sides of the lesion, double that measurement. For instance, taking a 4 cm margin on each side of the lesion equals a total of 8 reportable cm in addition to the diameter of the lesion itself.

The impact: If your surgeon doesn't put the original size in the note, you have to code based on the smaller excision size listed in the pathology report, which could cost your practice over \$20 per excision.

(Continued on next page)

Get Your CEUs Right Here!

Earn **0.5 AAPC CEUs*** FREE for this month's issue by passing an online quiz.

It's simple! Here's how:
Watch for the
"New CEU Test Available Online"
e-mail notice in your inbox.

Or log on to
www.coding411.com and click "Get AAPC CEUs".

**To obtain continuing education units (CEUs) from publications published in 2009, the American Academy of Professional Coders (AAPC) requires members to pass quizzes.*

Example: The surgeon's documentation states that he excised a lesion 1.0 cm length by 2.0 cm width with 0.2 cm margins. The pathology report comes back benign. You would report 11403 (*Excision, benign lesion including margins, except skin tag [unless listed else-where], trunk, arms or legs; excised diameter 2.1 to 3.0 cm*) for the 2.4 cm codeable size ([2.0 lesion diameter] + [0.2 x 2 margins]). If, however, the physician had failed to document the size and the pathology report measured a 1.0 cm lesion plus 0.1 margins, you could code only 11402 (... *excised diameter 1.1 to 2.0 cm*), resulting in a loss of \$21 (Code 11403 has 4.50 transitional nonfacility total relative value units [RVUs] compared to 11402, which the 2009 Medicare Physician Fee Schedule assigns 3.91 RVUs).

Important: You do need the pathology report to choose a code, but not for the size of the excision. You should always choose the malignant or benign excision code based on the results of the pathology report even if the physician did not know at the excision time that the lesion was malignant. The pathology report offers the definitive diagnosis that serves as the basis for the CPT excision code selection. A physician might sometimes visually identify a lesion as benign or malignant, but you still want to code the excision based on the pathology report.

— *Technical and coding advice for You Be the Coder and Reader Questions provided by Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO, manager of compliance education for the University of Washington Physicians (UWP) and Children's University Medical Group (CUMG) Compliance Program.* □

**Have a general surgery coding question?
Get help from our experts!**

Send your question to the editor, Leesa Israel, CPC, CPC-URO, CMBS, at leesai@elijournals.com or call (315) 986-2157.

SUBSCRIBE TODAY!

Yes! Enter my one-year subscription to *General Surgery Coding Alert* monthly newsletter for just \$397.

Extend! I already subscribe. Extend my subscription one year for just \$397.

Subscription Version Options: (check one) Print Online* Both* (Add online to print subscription FREE)

E-mail _____ * Must provide e-mail address if you choose "online" or "both" option to receive issue notifications

Payment Information Check enclosed: \$ _____ (payable to The Coding Institute)

Bill my credit card MC VISA AMEX DISC Exp. date _____

Acct. # _____ Signature _____

Bill me (please add \$15 processing fee for all billed orders) P.O. # _____

Name _____

Title _____

Office _____

Address _____

City _____ St _____ ZIP _____

Phone _____ Fax _____

E-mail _____



General Surgery Coding Alert
The Coding Institute
P.O. Box 933729
Atlanta, GA 31193-3229
Call (800) 508-2582
Fax (800) 508-2592
E-mail:
service@medville.com

Editorial Advisory Board

Gary W. Barone, MD

Associate Professor of Surgery
University of Arkansas for Medical Sciences, Little Rock

Suzan H. Berman-Hvzdash, CPC, CPC-EMS, CPC-EDS

Sr. Manager of Coding and Compliance
Departments of Surgery and Anesthesiology
University of Pittsburgh Medical Center
Pittsburgh, Penn.

John Bishop, PA-C, CPC

President Bishop & Associates, Inc.
Tampa, Florida

Judy Breuker, CPC, CCS-P, CHCC

CEO, Medical Education Services LLC,
Mich.

Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC

President, CRN Healthcare Solutions
Tinton Falls, N.J.

Tara L. Conklin, CPC

Independent Coding Consultant
Wesley Chapel, Fla.

Ian S. Easton, PhD, FACMPE

Past President, American College of
Medical Practice Executives
Department Head-Applied Technology,
Coastal Georgia College, Ga.

Terry A. Fletcher, BS, CPC, CCS-P, CCS

Healthcare Coding Consultant
President/CEO, Terry Fletcher Consultants,
Calif.
Member, American Academy of
Professional Coders

Arlene Morrow, CPC, CMM

President, AM Associates, Fla.
Seminar Leader, McVey Associates

Kathleen Mueller, RN, CPC, CCS-P

Healthcare Consultant, Ill.

Ron Nelson, PA-C

Clinical Practitioner
Reimbursement Policy Analyst
President, Health Services Associates, Mich.
Past President, American Academy
of Physician Assistants

Nancy Lynn Reading, RN, BS

CEO, Ceder Edge Medical Coding and
Reimbursement, Utah.

Terry Santana, RHIT, CCS, CCS-P, CPC

President, Quest for Quality Coding Inc.
Troy, Va.

Susan L. Turney, MD, FACP

Medical Director Reimbursement
Marshfield Clinic, Wis.