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Part B Insider (Multispecialty) Coding Alert

Colostomy Coding: Gain $200 By Noting Colectomy And Anastomosis

But beware billing separately for colectomy

When your surgeon takes down a colostomy, he may perform a resection and anastomosis as well. Instead of just **CPT billing 44620** (Closure of et-nerostomy, large or small intestine), you can bill 44625 (...with resection and anastomosis other than colorectal). You can make on average around $200 more for 44625 than for 44620.

It's important to check the operative report and see what the surgeon actually did, notes **Jan Rasmussen**, president of **Professional Coding Solutions** in Eau Claire, WI. Ideally, the surgeon will state that he performed a resection and anastomosis with the colostomy take-down. Other-wise, the operative report should "indicate that they cut out part of the intestine and sutured it together."

In some cases, though, you may want to bill for a colectomy or colon resection separately as well. Take this case: A patient comes in for a colectomy with anastomosis, but due to external factors the colectomy must be postponed, and instead the surgeon performs a colostomy. Then the patient comes back later and has the colostomy taken down and the colectomy with anastomosis completed.

In such a case, one coder says she billed for the colectomy separately using 44140 (Colectomy, partial, with anastomosis) and received payment. There's no Correct Coding Initiative edit bundling 44140 and 44625, so Medicare paid for that combination.

But Rasmussen says that the absence of an edit doesn't necessarily mean that you should bill those codes together. "That makes me uncomfortable," she says. "Usually what I would tell those people is don't spend the money, put it in the bank."

If it takes extensive extra time to perform the colectomy, then you may be able to use the -22 modifier, Rasmussen adds. "If it took significant additional work, the best way to report that would be with the -22 modifier."

"Unfortunately, the code doesn't say 'with minimal resection,'" Rasmussen adds.

One way to determine if the surgeon performed a colectomy, or how much extra work the colectomy involved, is to check the pathology report, notes Camden, SC general surgeon **M. Trayser Dunaway**. If the surgeon sent a six-centimeter section of colon to the lab for analysis, that's just from removing the colostomy. But if the lab received 18 inches of colon, you'll know the surgeon removed a lot more colon "because they didn't need it, there was more disease" or more perforation, says Dunaway.

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