Part B Insider (Multispecialty) Coding Alert

GENERAL SURGERY: Colostomy, Mucofistula May Spell Extra Reimbursement

Look for language specifying how the surgeon attached colon

When is a partial colectomy not a partial colectomy (44140)? When the surgeon doesn't reconnect two parts of the colon afterward.

Instead of reconnecting the two ends of the colon after a colon resection, the surgeon may create a colostomy, in which case you should bill 44141 instead. Or he may create a Hartmann's pouch, in which case you should bill 44143.

Or the surgeon may create a mucofistula (44144) or a low pelvic resection with anastomosis (44145), says general surgeon and coding educator **M. Trayser Dunaway** in Camden, SC. The surgeon also may use the abdominal and transanal approach, or the so-called "keyhole" approach, in which case you'd bill 44147.

Important: You should read your surgeon's operative note carefully to see if any unexpected complications led to a change in a planned partial colectomy, says Dunaway.

If the surgeon performed a mucofistula, a Hartmann's pouch or a low pelvic resection, then that means other circumstances are at work, Dunaway adds. Those procedures aren't part of a simple partial colectomy, also known as a hemicolectomy.

Look for unusual circumstances: Maybe the colon wasn't prepared properly, or there was fecal soilage, Dunaway speculates. Or maybe the patient's condition was deteriorating and the surgeon had to terminate the procedure in the middle. Also, the patient may have had a polyp that required an intraoperative biopsy (which you may be able to bill for separately, Dunaway notes).

Sometimes it's easier to create a mucofistula or Hartmann's pouch than to anastomose the two ends of colon, notes Dunaway.

Know your anatomy: Look for language that describes where the surgeon anastosed the colon, advises **Al Lewis**, a coder in Thomasville, GA. To understand the op report, you need to know the colon's anatomy.

The description of the anastamosis will make it clear whether it was large intestine to large intestine, small to large intestine, ileum to rectum or some other configuration, explains **Bobbi Bohon**, a coder with **Seven Hills Surgical Associates** in Lynchburg, VA. Pathology reports may also be helpful in figuring out what the surgeon resected.

If the surgeon resected the descending/sigmoid colon, you should look for anastomosis or suturing of the rectum stump to figure out which procedure your surgeon used, says **Michele Butler**, reimbursement specialist with **Columbia Surgical Specialists** in Columbia, SC. The surgeon may have created a suture to the rectal stump and end colostomy, meaning a Hartmann's pouch, or an anastomosis to the rectal stump with colostomy (44146).

To figure out if the surgeon used an unusual approach, such as abdominal and transanal, look for language that describes the surgeon's approach. A surgeon will describe a typical approach using language like, "a midline incision from the xiphoid process to the umbilical area," says Lewis.

Look for laparoscopic approach: Physicians are performing laparoscopic colectomies more often, says Butler. The

documentation may mention the surgeon used tocars and CO2 gas. You should bill for laparoscopic surgeries using the 4420x codes, plus the new add-on code 44213 for laparoscopic mobilization of the splenic flexure.

"Some coders get confused with the term 'hand-assisted laparoscopic colectomy,'" notes Butler. This means the majority of the procedure was laparoscopic, but the surgeon made a small opening to pull the colon out for excision or removal. It's still a laparoscopic procedure because the surgeon didn't make a full incision.