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Part B Insider (Multispecialty) Coding Alert

Make the Most of Colostomy Closures -- Here's How

Waiting for pathology results helps to optimize payment.

When reporting an enterostomy closure, you should immediately ask yourself, "Did the surgeon also perform resection and anastomosis of the bowel?" If so, you've got separately reportable services that can significantly boost the surgeon's compensation.

Select 44620 for Closure Only

For a basic takedown of enterostomy without bowel resection, you would report 44620 (Closure of enterostomy, large or small intestine).

What you'll see in the operative report: Documentation will describe taking down the stoma of the colon and sewing it back together. The closure can occur weeks or months after the initial colostomy procedure.

Example: The surgeon performs coloproctostomy with colostomy (44146, Colectomy, partial; with coloproctostomy [low pelvic anastomosis], with colostomy) for a patient with colon cancer. Four months later, the surgeon closes the colostomy without bowel resection.

You will report 44620 because the surgeon did not remove any tissue. Rather, he performed only anastomosis to reconnect the opened section of colon that had formed the colostomy.

For Resection, Zero in on Location

If the surgeon performs resection and anastomosis of the bowel at the same time as enterostomy takedown, you will report either 44625 (...with resection and anastomosis other than colorectal) or 44626 (...with resection and colorectal anastomosis [e.g., closure of Hartmann type procedure]), depending on which portion of the bowel the surgeon addresses.

For resection anywhere but the colorectal area (the sigmoid colon, for instance), you would report code 44625.

If the surgeon resects the colon in the colorectal area, you will instead code 44626.

Note that payers will reimburse at a higher rate for 44626 than for 44625. This is because, "Colorectal surgeries are generally more difficult because of the lower pelvic nature of the exposure and subsequent anastamosis," explains **M. Tray Dunaway, MD, FACS, CSP,** a surgeon, author, speaker, and coding educator with **Healthcare Value, Inc.** in Camden, SC.

Double check: Resection and anastomosis often accompany a closure. If the surgeon doesn't indicate that he performed a resection, you should request the pathology report, if one is pending, before billing the procedure. The report can reveal to you if and where any resection occurred.

Tip: If the resection isn't included in the surgeon's narrative, you shouldn't bill for it. If the pathology report suggests the surgeon performed a resection, discuss this with the surgeon and recommend that the surgeon correct the dictation to reflect all the work he performed.

Cash advantage: The current CMS fee schedule assigns 14.35 physician work relative value units (RVUs) to colostomy closure 44620, but assigns 17.20 RVUs to closure with "other than colorectal" anastomosis (44625) and 27.82 RVUs to closure with colorectal anastomosis (44626). The difference in payment among these codes -- and thus the cost of

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improper coding -- can exceed $450, on average, for Medicare payers across the country.

Watch for Separate Resection

Note that if the surgeon resects the bowel at a location separate from the enterostomy takedown, you may be able to report the resection and takedown as independent procedures, using two separate codes.

Example: The surgeon sees a patient with severe abdominal pain, a history of diverticulosis, and rebound tenderness. The surgeon performs an exploratory laparotomy of the abdomen and identifies severe diverticulitis --in this case, a large abscess in the sigmoid colon.

The surgeon decides not to resect the sigmoid and instead performs a transverse loop colostomy (44320, Colostomy or skin-level cecostomy; [separate procedure]). In addition, the surgeon drains the peritoneal abscess (49020, drain-age of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; open).

At a later date, when the inflammation and infection have resolved, the surgeon performs sigmoid colectomy with primary anastomosis (44145, Colectomy, partial; with coloproctostomy [low pelvic anastomosis]). The surgeon can elect to close the original loop colostomy simultaneously, or wait until the low pelvic anastomosis has healed and return the patient to the operating room for the colostomy takedown, Dunaway explains.

If the surgeon performs the anastomosis and takedown during the same session, report both 44145 and 44620. Append modifier 59 (Distinct procedural service) to 44620 to indicate that the closure of the original loop colostomy occurred at a different site (for example, transverse colon) than the partial colectomy of the sigmoid colon.

However, if the surgeon performs the anastomosis and waits to take down the original colostomy until a later date, you would report 44145 for the initial surgery. You'd then report 44620 (without modifier 59) for takedown of the initial colostomy at a later date.

Additional modifier note: When a resection occurs within the global period of the loop colostomy, you should append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the resection code 44145, Dunaway reminds.

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