Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Guarantee Success With This Lap App Coding Roadmap

Don't throw money down the drain-know when to append modifier 22

You face it everyday--the pressure to code dense medical reports quickly and correctly. What to do: Follow our step-by-step guide to coding this laparoscopic appendectomy (see sample report, below). You can apply our experts' tips to any operative report you pick up--boosting your efficiency and triumphing over common coding pitfalls.

7 Steps To Coding Success

Step 1: Prep your workspace--have all your tools in front of you while you code, says PMCC instructor **Susan Vogelberger, CPC, CPC-H**, coder and office coordinator with the **Orthopedic Surgery Center** at Beeghly Medical Park in Ohio. Keep a medical dictionary, an anatomy book and the current year's CPT, ICD-9 and HCPCS Level II manuals handy, she advises. Make sure you have access to the Correct Coding Initiative edits and consider other coding publications that will help you code, she adds.

Step 2: Check the top of the op note to get a preliminary idea of what procedure the physician performed, suggests Vogelberger.

Our sample report tells us that we will probably be coding a laparoscopic appendectomy. But don't stop there.

Step 3: Read the whole report, says PMCC instructor **Kim Garner Huey, CPC, CCS-P, CHCC,** with **KGG Coding and Reimbursement Consulting** in Auburn, AL. Many coders make the mistake of coding from the title or make an assumption based on the diagnosis, she remarks.

Studying the full report will tell you if the doctor performed more or less than the title indicates--or if he terminated the procedure entirely, Vogelberger warns.

Expert tip: Make a copy of the operative note so you can underline or highlight key sections as you read through it, suggests Vogelberger. You don't want to mark up the original because you may need a clean version for a payor or auditor.

Step 4: Choose your CPT codes. After checking the title and the body of our sample report, you know that you're looking for a laparoscopic appendectomy code.

Smart: If your report isn't specific about whether it's a laparoscopic or open procedure, turn to your vocabulary skills, says Huey. Look for key words such as "insufflated" and "ports" for laparoscopic procedures. And study the different types of incisions physicians use, such as midline (a vertical abdominal incision between the rectus muscles) and Pfannenstiel's (transverse incision through the recti muscles' external sheath), she continues. These incisions usually indicate an open procedure.

Ideal documentation should mention the laparoscope, but doctors often omit it. Let your physician know that his report needs to state "laparoscopic" or "open," both for coding and in case of carrier or auditor review.

Sample Operative Report

CPT® 2023 American Medical Association. All rights reserved.

Preoperative Diagnosis: Perforated appendicitis

Postoperative Diagnosis: Perforated appendicitis

Operation: Laparoscopic appendectomy

Description of Procedure: The patient was placed on the operating table in a supine position. After an adequate level of general endotracheal anesthesia had been achieved, her abdomen was prepped and draped in the usual sterile fashion. We insufflated with a Hasson cannula placed at the umbilicus. Two 5 mm ports were placed in the left lower quadrant. The appendix was obviously perforated. There was pus in the pelvis up along the right gutter over the liver and also in the left upper quadrant. The perforation in the appendix was visible. We freed up the appendix from the omentum that attached itself to the perforated appendix. We then took the mesoappendix with the LigaSure device. We then took the appendix at its base on the cecum with an Endo-GIA stapler. We brought the appendix out through the umbilical port in a specimen bag. We reinsufflated the abdomen and then irrigated in the pelvis, in the left and the right upper quadrant, and throughout, trying to remove all the purulent fluid that we could. When this was completed, we desufflated the abdomen; we removed our ports; and the umbilical wound was closed with a figure-of-eight Vicryl stitch. Each of the wounds was copiously irrigated and closed with subcuticular suture and Indermil tissue adhesive. The patient was taken to the recovery room in good condition. She tolerated the procedure well. There were no complications.

Next: Once you've narrowed your procedure down, you can search your CPT manual. For a laparoscopic appendectomy, the CPT index points you to code 44970 (Laparoscopy, surgical, appendectomy).

But you may not want to settle for simply reporting this code.

Why: The sample report above is a reminder that a title may not reflect everything in the body of the report, notes **Jan Rasmussen, CPC**, with **Professional Coding Solutions** in Eau Claire, WI. A laparoscopic procedure for a ruptured appendix with pus in the peritoneal cavity may require more work than one with no rupture. Plus, the added risk for infection means this surgeon faces "tremendous liability in the post op period," she notes.

The codes for open appendectomies (44950-44960) include an option specifically for a ruptured appendix (44960, Appendectomy; for ruptured appendix with abscess or generalized peritonitis), she says. This code may pay $100 more than a basic appendectomy.

Problem: You only have one code--44970--to represent a laparoscopic appendectomy, which pays about $200 less than 44960.

What to do: If your documentation supports coding additional work because of the rupture, append modifier 22 (Unusual procedural services) to your CPT code, says Vogelberger.

Try this: Find additional support for coding choices outside the op report, says Huey. The anesthesia report may help if the patient suffered complications or the procedure took longer than normal, she offers. You may also have access to a "circulating sheet" or "nurse's notes." Benefit: The nurse completes this documentation during the procedure, as opposed to an op report which the physician dictates afterward.

Good idea: Compare the time the procedure actually took to the scheduled operating time. Include any substantial difference in your cover letter as proof of the extra work involved. Many payors will only pay you extra for a 22 claim if you prove your doctor performed 25 percent more work than usual for a particular procedure.

Best bet: Only use 22 when you're confident you've got stellar documentation of extra work--carriers are suspicious of coders overusing 22. A "special circumstances" section in the report may bolster a 22 claim.

Step 5: Search National Correct Coding Initiative (NCCI) edits for bundled codes, says Vogelberger. This step is vital to keep you compliant and to earn you the proper reimbursement, she adds.

CPT® 2023 American Medical Association. All rights reserved.

Application: NCCI bundles many codes for services integral to the laparoscopic appendectomy into 44970, such as 36000 (Introduction of needle or intracatheter, vein). This edit has a modifier indicator of "1," which means that if you perform the two separately, you may break the bundle with a modifier. Other edits, such as 44200 (Laparoscopy, surgical; enterolysis) and 44970, have a "0" modifier indicator, which tells you not to break the bundle.(Note: Download the latest edits on the CMS Web site at www.cms.hhs.gov/physicians/cciedits/).

Step 6: Decide on your diagnosis code. In our report, the pre-op and post-op diagnoses are the same--perforated appendicitis. Your ICD-9 manual index entry for "Appendicitis with perforation, peritonitis (generalized), or rupture," points you to 540.0 (Acute appendicitis with generalized peritonitis). Checking this code in the tabular list confirms that 540.0 is the most appropriate code for our report.

Helpful: The ICD-9-CM Diagnosis Coding Guidelines tell you to use the post op diagnosis if it differs from the pre-op diagnosis, reports Huey.

Remember: You should only code a definitive diagnosis. The guidelines tell you not to code diagnoses documented as "probable," "suspected," "questionable," "rule out" or "working diagnosis." Instead: Code the conditions to the highest degree of certainty for that encounter, even if this means symptoms, signs, abnormal test results or another reason for the visit.

You'll find the official guidelines at www.cdc.gov/nchs/data/icd9/icdguide.pdf. And CMS offers comprehensive ICD-9-CM assistance at www.cms.hhs.gov/paymentsystems/icd9/default.asp.

Step 7: Inspect your choices. Glance back over your coding to be sure you reported the correct codes and add any modifiers the documentation warrants.

Bottom line: Avoid taking shortcuts when coding operative reports. Ignoring bundles or coding from the title will lead to costly mistakes. Win appeals by sending in top-notch documentation and convincing cover letters.

CPT® 2023 American Medical Association. All rights reserved.