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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Master Spleen Codes With This Splenomegaly Case

This 'separate procedure' doesn't always stand alone.

When your surgeon removes or repairs a spleen with or without other surgical procedures, do you know how to choose the right codes?

Read on to make sure you don't leave money on the table by missing additional services or over charge for services by billing for bundled spleen.

Study Case and Codes

CPT® provides six codes for spleen procedures:

- 38100 Splenectomy; total (separate procedure)
- 38101 ... partial (separate procedure)
- 38102 ... total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)
- 38115 Repair of ruptured spleen (splenorrhaphy) with or without partial splenectomy
- 38120 Laparoscopy, surgical, splenectomy
- 38129 Unlisted laparoscopy procedure, spleen

Study the following case, then gather our expert advice about how to choose the proper coding:

Operative report: Performed midline celiotomy from 3 cm below xiphoid process to 3 cm above the umbilicus. The peritoneum was entered and the left upper quadrant fully visualized, noting grossly enlarged spleen and intraperitoneal blood. Performed abdominal exploration, noting abnormal colonic mesentery lymph nodes. Divided splenorenal ligament, took down short gastric adhesions, and divided superior and inferior pole vessels, removing spleen with cautery and clamps to control bleeding. Removed colonic mesenteric lymph nodes.

Identify Partial or Total Resection

Based on the surgical report, you can see that the surgeon removed the entire spleen. That means you can rule out 38101, which describes a partial splenectomy. You can also rule out the unlisted code, 38129, because CPT® provides more specific codes for total spleen removal.

Not repair: Reserve the repair code (38115) for cases where the surgeon performs splenorrhaphy rather than removing the spleen either through an open or laparoscopic surgical approach. That means 38115 is not the correct code for this case.

Chose Open or Laparoscopic

Once you've determined that the procedure is a splenectomy, you still don't have enough information to pinpoint which

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code to use. In fact, you have three splenectomy CPT® codes to choose from: 38100, 38102, or 38120.

"The first thing you need to identify is whether the procedure is open or laparoscopic," advises **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC**, audit manager for CHAN Healthcare in Vancouver, Wash.

Because the op report describes a midline incision, you should use one of the open codes 38100 or 38102.

Look for Other Procedures

The surgical case in this example involves an open splenectomy for an enlarged spleen, so the best code choice is 38100.

"You should reserve 38102 for a larger resection of a block of visceral organs that includes the spleen and is involved in extensive disease, such as a metastatic malignancy," Marcella says.

For instance, if the surgeon removed a gastric carcinoma involving the spleen and a portion of the stomach, you should report 38102 for the spleen excision. "You should additionally report the gastrectomy procedure," Marcella says. For instance, you might list 43631 (Gastrectomy, partial, distal; with gastroduodenostomy) or other code, depending on the op report.

Include exploratory laparotomy: Although the surgical note describes "abdominal exploration," you should not separately bill an exploratory laparotomy (49000, Exploratory laparotomy, exploratory celiotomy with or without biopsy[s] [separate procedure]) in addition to 38100. "Laparotomy is an integral part of splenectomy, so it's included in the 38100 code," Bucknam says.

Don't miss other services: The operative note states that the surgeon removed colonic mesenteric lymph nodes. The lymph node biopsy is not an integral part of a splenectomy, so you can separately report the service. Because CPT® doesn't provide a specific code for open mesenteric lymph node sampling, you should report 38999 (Unlisted procedure, hemic or lymphatic system).

Beware "Separate Procedure" Bundles

The splenectomy case in this example isn't part of a more extensive procedure. But if your surgeon performs a total or partial splenectomy in addition to another surgical procedure, you'll need to use caution when deciding whether you can separately report 38100 or 38101.

CPT® uses the "separate procedure" designation in code descriptors to identify procedures that the physician normally performs as a part of another, more extensive procedure, but which he may provide independently, in some cases.

The separate procedure designation means that the procedure is bundled and therefore not separately reportable anytime the physician provides a more extensive, related service.

For instance: If the surgeon excises a portion of the stomach (such as 43631) and incidentally removes the adjacent spleen, you can't separately report the splenectomy as 38100. In agreement with this CPT® limitation, Medicare's Correct Coding Initiative bundles 43631 and 38100.

Remember: You can override the edit pair if the two procedures don't take place in the same anatomic region. Also recall that you can separately report the splenectomy using 38102 if it is an en bloc resection for widespread disease related to the more extensive procedure.

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