Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Perfect Your Cholecystectomy Claims--Our Expert Advice Shows You How

Open vs. laparoscopic is one of several important factors

Do you want to be sure that you-re reporting cholecystectomy claims correctly--without leaving money on the table? Here are four steps that will allow you to tackle that operative note with confidence.

1. Choose Between Open and Laparoscopic Approach

To begin, you must determine whether the surgeon performed the cholecystectomy via an open approach or using a laparoscope. For laparoscopic procedures, you should choose your code from the 47562-47564 range. For open cholecystectomy, you should stick with 47600-47620. Use the chart on the next page for quick reference when selecting a cholecystectomy code.

2. Report All Associated Procedures

As indicated in the chart, you must also consider whether the surgeon performed any other procedures at the time of the gall bladder removal, such as cholangiography or common duct exploration. Failure to report these procedures, when performed, means that your surgeon will not receive all the reimbursement he deserves for his effort.

For example: -Many surgeons perform cholangiography [radiologic examination of the bile ducts] as a standard component of cholecystectomy,- says **M. Trayser Dun-away, MD, FACS, CSP, CHCO, CHCC,** a surgeon, speaker, physician and coding educator, and healthcare consultant in Camden, S.C. -Because the surgeon considers the cholangiography routine, he or she may fail to note the procedure in the operative report summary. If you don't read the body of the operative report, you may miss the cholangiogram, as well as the reimbursement that comes with it.-

Avoid this overcoding mistake: If the surgeon performs both cholangiography and exploration of the common bile duct (to locate and remove gallstones, for instance), you should report only 47564 (Laparoscopy, surgical; cholecystectomy with exploration of common duct) for laparoscopic approach or 47610 (Cholecystectomy with exploration of common duct) for an open procedure.

Here's why: The **National Correct Coding Initiative** (NCCI) bundles 47563 (Laparoscopy, surgical; cholecystectomy with cholangiography) into 47564, and likewise includes 47605 (Cholecystectomy; with cholangiography) in 47610. Both edits include a -0- modifier indicator, meaning that you may never override them. Payers will always include the work involved in cholangiography in exploration of the common ducts.

3. Claim Only Open Procedure for Conversions

If, during a laparoscopic cholecystectomy, the surgeon must convert to an open surgery due to inflammation, extensive adhesions or other complications, you should report the open procedure only, according to CPT and CMS guidelines.

Coding example: During the initial approach of a lap chole, the surgeon finds that the patient's gallbladder is severely inflamed and surrounded by difficult adhesions. The surgeon decides to abandon the laparoscope and perform an open (excisional) cholecystectomy instead. In this case, you should report 47600 (Cholecystectomy).

Don't report a -failed- lap chole: Because the surgeon began with a lap chole, you may be tempted to report 47562 with modifier 53 (Discontinued procedure) in addition to 47600, but this is incorrect.

4. Append 22 if Circumstances Warrant

If the surgeon encounters unusual difficulties when performing a cholecystectomy, you may be able to append modifier 22 (Unusual procedural services) to the claim to gain additional payment for the increased effort.

You should always apply modifier 22 sparingly, but in cases when a surgery may require significant additional time or effort that falls outside the range of services described by a particular CPT code--and no other CPT code better describes the work involved in the procedure--modifier 22 is your best option, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO,** owner of **MJH Consulting** in Denver.

Example: During a routine laparoscopic gallbladder surgery (lap chole), the surgeon finds that there are a few stones in the patient's common duct that take an additional two hours to remove through the scope. There are no extra codes to report in this case, so you could choose to append modifier 22 to 47564 if the surgeon sufficiently documented the additional effort.

Conversions may also call for 22: If the surgeon spends a long time attempting to complete a laparoscopic procedure before ultimately converting to an open approach, you may be able to access modifier 22 to account for the extra effort and boost reimbursement, Hammer says.

-Often surgeons spend more time trying to perform the laparoscopic procedure than it would usually take to perform the entire procedure,- says **Marcella Bucknam, CPC, CCS, CPC-H, CCS-P,** charge capture manager for the **University of Washington Physicians**. -If the surgeon decides he has to convert, he has the additional work of starting over. If the surgeon describes this process well, payers will often provide additional reimbursement for this additional time and work.-

Example: After spending 50 minutes lysing adhesions laparoscopically and moving toward the gallbladder, the surgeon encounters excessive inflammation. Due to these complications, the surgeon decides to abandon the scope and proceed with an open approach.

In this case, because of the significant additional effort, you may append modifier 22 to 47600.

Important: All conversions won't warrant modifier 22: To gain additional payment, the documentation must firmly establish why the additional effort was necessary.