Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Stop Forfeiting Up to $779 for Appendectomy Procedures

2 requirements open the door to adding on 44950 to 44970.

Do you assume payers will bundle appendectomies into most other abdominal procedures? Automatically skipping over the appendectomy codes for every case could cost your surgeon approximately $80 to $779 in deserved reimbursement.

There are circumstances when you can -- and should -- separatelyreport appendectomy procedures. Here's how to capture added pay without unbundling.

'Healthy' Removal = No Pay

Medicare and most other payers will not pay separately for the removal of a healthy appendix.

Reasoning: Surgeons may perform appendectomies during the course of more extensive abdominal procedures.Sometimes, the surgeon will even remove a healthy appendix simply because he already has the patient's abdomen open and removing the appendix eliminates a potential health problem down the road. In fact, finding appendicitis in a patient during the course of another procedure is not a common occurrence, experts say.

Example: Your surgeon may remove a patient's appendix during bariatric surgery (for example, 43846, Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb [150 cm or less] Roux-en-Y gastroenterostomy).

Unless the appendix appears abnormal (with scarring or inflammation, for example), you must consider the appendectomy incidental to the surgery, and you should not report that procedure separately.

To avoid paying for removal of healthy appendixes, many payers will expect you to provide proof (such as an op report) that an appendectomy your surgeon performed during the same session as another procedure was medically necessary.

Dx Supports Separate Appendectomy Payment

If you overlook +44955 (Appendectomy; when done for indicated purpose at time of other major procedure [not as separate procedure] [List separately in addition to code for primary procedure]), you're costing your practice $78.99 (2.19 relative value units [RVUs] times the 2009 conversion factor of $36.0666). You can separately report an appendectomy if the procedure meets two requirements:

1. Your surgeon clearly documented a problem with the appendix

2. Other procedures during the same session do not relate directly to the right colon.

When your physician performs a medically necessary appendectomy at the same time as another procedure, you'll turn to +44955. You will report +44955 in addition to the primary procedure performed.

Key: You should apply a separate diagnosis to the appendectomy code you report to prove to the payer that an appendectomy was medically necessary, says **Karla D. Garcia, CPC,** coder for Drs. West and Mayo in Paducah, Ky. If you cannot supply a separate diagnosis, such as appendicitis (540-543,

Appendicitis, as appropriate), chances are that the removal wasn't required because of immediate health concerns, and you shouldn't be separately reporting the appendectomy anyway.

How it works: Note the use of "indicated purpose" in +44955's descriptor. This means that there must be a separate, medically necessary diagnosis or signs and symptoms to justify the appendectomy.

Scenario: The patient has a gallbladder problem, and while performing the gallbladder removal, the surgeon finds appendicitis as well, so he performs an appendectomy. In this case, you should report +44955 as well as the cholecystectomy (for example, 47562, Laparoscopy, surgical; cholecystectomy).

No Specific Dx? Don't Give Up

If your surgeon doesn't have a specific diagnosis before opening the patient, you should report the applicable signs and symptoms. If the pathology report shows disease, use that information to assign the primary diagnosis.

"Always make sure that your codes are supported by both your physician's documentation and your path report," cautions **Sundae Yomes, CPC,** trauma services coder at HCA Physician Services in Las Vegas. Waiting for the pathology report to come back is good practice, Garcia says. Drs. West and Mayo often perform lap appendectomies with lap cholecystectomies.

Garcia always waits for the pathology report to decide whether to separately report the appendectomy.

Alternative: Even if the pathology report returns negative for appendicitis, you can still report +44955 "as long as the physician's documentation clearly states the reason he is removing the appendix," says **Monika A. Liddle, CPC, CGSC, PCS,** surgical coding coordinator for Martin Memorial Health Systems in Stuart, Fla. The fact that the pathology didn't come back with a disease diagnosis doesn't automatically negate that the surgeon performed the removal for a specified reason. "I would still code whatever the physician documented, and hopefully he documents well," Yomes says.

Watch for +44955 Exceptions

Code +44955 is not your only choice for appendectomy. Depending on the circumstances, you may select from three additional codes:

• 44950 (Appendectomy).

Report 44950 when the appendectomy is the only procedure your surgeon performs during the session. Not reporting 44950 will cost you $579.59 (16.07 RVUs times the 2009 conversion factor of $36.0666).

• 44960 (... for ruptured appendix with abscess or generalized peritonitis). Overlooking 44960 means you're forfeiting $778.68 (21.59 RVUs times $36.0666).

• 44970 (Laparoscopy, surgical, appendectomy). If your surgeon removes only the appendix laparoscopically, you instead should select 44970, Liddle says.

Reporting 44970 will bring you an additional $532.34 (14.76 RVUs times the 2009 conversion factor of $36.0666).

You will report 44950/44970 only if the patient's appendix has not burst, Garcia warns. "I won't use the codes that specifically identify a rupture with abscess or peritonitis unless the physician states it, or the path shows that that's what the final diagnosis is," Yomes agrees.

On the other hand, if your surgeon removes a ruptured appendix, you would report 44960.