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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Tackle Any Foreign-Body Removal With This Expert Guidance

4 case studies show you how to secure FBR reimbursement

If you always report a 20000-series code for foreign body removal, you'll need to think twice before filing another claim.

CPT does not employ a uniform set of guidelines for reporting removal of foreign bodies. That means coding for foreign-body removal (FBR) can vary greatly depending on the type of foreign body, its anatomic location and the depth from which the physician must remove it.

Compare your toughest FBR claim to one of our four case studies, and you're sure to find the solution you need to tricky FRB coding scenarios.

Case #1: No Incision Means No Separate FBR

The situation: While operating a metal lathe, the patient embeds several small metal filings in his shoulder. In the office, the physician inspects the wounds and uses tweezers to extract the shards.

The solution: Because the physician did not create a separate incision to remove the foreign bodies, you cannot code an FBR, says **Tara L. Conklin, CPC**, an instructor for **CRN Institute**, a coding and reimbursement institution offering courses in reimbursement, medical billing, outpatient coding certification and inpatient coding certification. Rather, you should include the removal of the metal filings as a component of whatever E/M service the physician documents (for example, **CPT 99213** , Office or other outpatient visit for the evaluation and management of an established patient ...).

The "what if?" scenario: The patient received deep wounds when he was hit by flying debris from an exploding propane tank. The physician explores the open wounds, removes several pieces of debris, and debrides and closes the wounds.

In this case, the physician performed wound exploration (20100-20103) with removal of the foreign body, which you should report using the wound exploration code that best describes the anatomic location of the wound the physician explored (such as 20101, Exploration of penetrating wound [separate procedure]; chest). Removal of foreign bodies is included in wound exploration codes.

Case #2: For Musculoskeletal FBR, Code by Location and Depth

The situation: Say the patient in case study #1 removes the metal filings himself. After several weeks, his wounds heal, but one metal filing remains and has now become imbedded in the muscle beneath the skin. The physician sees the patient and removes the foreign body from the patient's shoulder through an incision.

The solution: When reporting FBR from a musculoskeletal site (muscle or even bone), you must select the correct FBR code by anatomic location and depth, Conklin says.

The musculoskeletal portion of CPT (20000-29999) includes specific FBR codes for the shoulder, humerus (upper arm) and elbow, hip, femur (thigh region) and knee joint, and feet and toes. CPT further defines these codes according to depth (such as subcutaneous, deep or complicated).

For example, for FBR in the shoulder, you must select among codes 23330 (Removal of foreign body, shoulder;

subcutaneous), 23331 (...deep [e.g., Neer hemiarthroplasty removal]) and 23332 (...complicated [e.g., total shoulder]). If the physician removes the foreign body from the subcutaneous tissue or anywhere else above the fascia, you would select 23330. If the physician must go below the fascia, use 23331. In the case of a particularly complex procedure (such as when the whole shoulder area is involved), you should select 23332, Conklin says.

In case #2, your best code selection is 23331.

The "what if?" scenario: The physician must remove a foreign body from just above the fascia near the navel.

Because CPT does not contain a specific code for FBR from the abdomen, you must select from between 20520 (Removal of foreign body in muscle or tendon sheath; simple) or 20525 (...deep or complicated). You would also select these codes for other "unlisted" areas, such as head, neck, flank, spine, wrist/forearm and fingers.

In this case, you should select 20520 because the foreign body was not below the fascia.

Case #3: FBR From Stomach? Choose 40000-Series

The situation: An 8-year-old child swallows a small battery. Using an endoscope, the physician removes the foreign body from the child's stomach.

The solution: You will find FBR codes for endoscopic removal from the intestine, stomach, colon, rectum and other sites in the Digestive System section (40000 series) of CPT.

In this case, you should report 43247 (Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with removal of foreign body), says M. Trayser Dunaway, MD, a general surgeon in Camden, SC.

The "what if?" scenario: The physician cannot safely remove the foreign body from the child's stomach using the endoscope and must create an incision to retrieve the object.

The 40000 series also contains codes to report open explorations for FBR at specific sites. For example, the code for open FBR from the stomach - and the correct code in this instance - is 43500 (Gastrotomy; with exploration or foreign-body removal).

Case #4: Scope May Not Call for Separate Code

The situation: The physician manually removes a previously placed percutaneous endoscopic gastrotomy (PEG) tube.

The solution: Although the PEG tube is technically a foreign object (in other words, it is not a natural part of the patient's body), CPT classifies PEG tube removal as an incidental service and does not contain a code to describe the procedure. Therefore, the physician may report only appropriate-level E/M codes to describe his service, Dunaway says.

The "what if?" scenario: During a manual PEG tube removal, a piece of the tube breaks off. The physician must use the endoscope to retrieve the broken portion of the PEG tube from the patient's stomach.

In this case, you may use the endoscopic foreign-body removal code 43247, Dunaway says.

Chapter 6 of the National Correct Coding Initiative stipulates, "CPT code 43247 is not to be reported for routine removal of therapeutic devices previously placed." But this is not a "routine removal," so you can report code 43247. That means there is no way to remove the portion of PEG tube manually in such a case.

Your documentation should make clear, however, the necessity of using the scope to retrieve the portion of the broken tube. With-out documentation, the payer will likely reject the claim.

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