Part B Insider (Multispecialty) Coding Alert

Reader Question: Conversion to Open Procedure Warrants Open Code Only

Question: My doctor did a laparoscopic cholecystectomy with intraoperative cholangiogram. He then converted to an open procedure to do a common bile duct exploration followed by a choledochoscopy. He also performs a Ttube cholangiogram, and placed an ON-Q pain catheter.

How should I code this?

Answer: You shouldn't report both 47563 (Laparoscopy, surgical; cholecystectomy with cholangiography) and 47610 (Cholecystectomy with exploration of common duct) because you'd be trying to get reimbursement twice for the cholecystectomy. Since Correct Coding Initiative (CCI) bundles the bile duct exploration into the cholecystectomy with cholangiography, and the physician converted to open, you'd report the open cholecystectomy code (47610). The bundle includes a "0" modifier indicator, meaning that you may never override the bundle.

Remember: When the surgeon converts from a laparoscopic procedure to an open procedure, you're only supposed to report the open procedure code.

Next step: Whether you can report +47550 (Biliary endoscopy, intraoperative [choledochoscopy]) depends on the reason for the choledochoscopy. When the surgeon uses the scope after a procedure to confirm that everything is okay, you cannot separately code for it. If there is some separate medical necessity for the scope (like the surgeon didn't think he got all of the stones, or there was excess bleeding or reduced bile), then the scope is separately reportable.

Caution: You cannot separately report pain catheters, either. For most payers, you cannot charge separately for placement of the ON-Q pain pump. Chapter 1 of the CCI clearly states, "insertion and removal of drains, suction devices, dressings, [and] pumps" into the same site as the primary procedure are "generic services integral to standards of medical/surgical services." In other words, such services are not separately reportable or payable. Local Medicare payers may provide specific local coverage determinations that explain, for instance, "Payment for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and, therefore, is not eligible for separate payment." Therefore, for this procedure you would report just 47610 and 47550, if the documentation proves medical necessity for the scope.