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Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: Make Sure You're Billing The Correct Codes

Don't miss out on splenic flexure, lesion repair

Important: Don't assume a code is bundled into a procedure or visit if the Correct Coding Initiative or CPT rules don't say so. You could be missing out on reimbursement and coding incorrectly, experts say. Here are some more examples of off-the-radar codes that, if put to proper use, could pay off for your practice:

• If your physician performs a **mobilization (take-down) of the splenic flexure** in the process of performing a partial colectomy, you can bill for this separately using 44139, says **Barbara Cobuzzi**, president of **CRN Healthcare Solutions** in Tinton Falls, NJ. Medicare reimburses approximately $1,000 extra for 44139 because of the difficulty and complexity of eliminating the splenic flexure, the junction nearest the spleen (See PBI, Vol. 4, No. 27). But many coders fail to note that the surgeon mobilized the splenic flexure when they code a procedure.

Note: If the splenic flexure take-down was laparoscopic, you should use 44213 instead of 44139.

• When your physician **excises a benign or malignant lesion**, double-check whether he or she also performed an intermediate or complex repair, Cobuzzi urges. Medicare won't pay for a simple closure with a lesion excision, but many coders don't realize that Medicare will pay separately for an intermediate or complex repair.

• Similarly, when your physician uses a **graft to repair the donor site of a flap or microcellular graft**, which was used for a reconstruction, you can bill for the graft separately, says Cobuzzi. If the donor site merely required a simple, intermediate or complex repair, you can't bill separately, but if it required a graft or flap, you can bill separately using codes 15200-15261. You can also bill separately for casts or splints to immobilize donor sites, Cobuzzi adds.

• Many coders forget that Medicare will pay separately for the "Q" codes for **casting materials**, along with cast application, notes **Adrienne Rabinowitz,** certified professional coder and billing manager with **Orthopedic Spine Specialists** in York, NJ. Because non-Medicare payors often won't cover these supplies, coders mistakenly think Medicare won't cover them either. Generally, each CPT code for application will have four matching "Q" codes, broken down into adult versus pediatric and plaster versus fiberglass.

Also, all payors will pay forecasting during the global period after a procedure. Only initial cast application is included in the global period for most procedures, Rabinowitz points out.

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