Part B Insider (Multispecialty) Coding Alert

Surgical Coding: Straighten Out Your Surgery Claims With These 5 FAQs

We took the most-often asked surgery questions and answered them to share with our readers.

You may not have the words "general surgery" above your practice's name, but chances are that you perform some type of surgical procedure—even as minor as those with an "XXX" global period—a few times a week. To quell any surgical billing and coding questions you might have, we compiled the most often-submitted questions and boiled them to down to five FAQs so you can start collecting appropriately for your surgery services.

Count Carefully When It Comes to Global

Question: A patient saw our physician because of an abscess, and returned for a follow-up a few days later. Can we charge anything for the follow-up visit if we just examined the site and changed the bandages?

Answer: The answer depends on what service your physician provided during the initial visit. If he performed an incision and drainage (I&D) of a skin abscess, you probably reported 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single). If so, 10060 includes a 10-day follow-up period. If the patient returned to your office within that 10-day period, the follow-up service is included in the global package.

If the physician did not perform a therapeutic procedure during the initial visit and simply bandaged the abscess with instructions to return in follow-up a few days later, you'll report the appropriate E/M code, such as 99212 (Office or other outpatient visit for the evaluation and management of an established patient ...), at the time of follow-up.

Know When Modifier 80 Applies

Question: I'd appreciate some help with how to bill for the following scenario for a patient with a vena cava thrombus during a kidney removal:Physician A and an assistant physician B, both in the same group, performed an open radical nephrectomy without taking regional lymph nodes. A vascular surgeon was called in to help with the evacuation of vena cava thrombus, which he performed with the assistance of physician A. Because the vascular surgeon is new to this area and is not credentialed, he will not be billing for his portion of the procedure.

Answer: You should bill 50230 (Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) for physician A and 50230-80 (Assistant surgeon) for physician B. Notice that this code describes nephrectomy with regional lymphadenectomy and/or vena caval thrombectomy, so the fact that lymph nodes were not taken doesn't impact the code choice, and you don't have to report "reduced services."

Since physician A participated in the thrombectomy and the vascular surgeon is not going to bill, you should list surgeon A as the primary surgeon and surgeon B as the assistant. Recall that an assistant surgeon doesn't have to be present for the entire procedure or all parts of the procedure. Also note that thrombectomy work can be quite various for different cases, from a fairly minor component to an extensive thrombectomy, so Surgeon A's work, whatever it was, can be used to bill the code.

Caveat: There are a couple of other factors you should take into consideration. For one thing, you should bill this code for Surgeon A only if he describe the thrombectomy as part of his op note, even if it says the vascular surgeon also worked on it. However, if surgeon A documents only that he assisted the vascular surgeon "see his note for details" or something like that, you should not list 50230. Instead, you should bill only for the nephrectomy (e.g., 50220,

Nephrectomy, including partial ureterectomy, any open approach including rib resection) and leave the thrombectomy money on the table. Without a description of the thrombectomy as part of surgeon A's report, it would never stand up to review if that was needed.

Final caution: Some payers are pretty tough on the subject of having physicians who are not credentialed with the payer providing services for their patients. You need to be aware of payer rules before you bill this case.

Know Incision Vs. Aspiration Rules

Question: A patient presented with a peritonsillar abscess (PTA) and underwent a needle aspiration to confirm the presence of pus in the tissues. During this procedure, the physician determined that the abscess could be drained completely with the needle aspiration. He subsequently used an 18-gauge spinal needle and aspirated the pus with a 10-cc syringe. When attempting to bill for this, I noticed that the only codes addressing a PTA involve "incision and drainage." What code is best used to bill an aspiration without an incision?

Answer: If no incision was made, you might consider code 10021 (Fine needle aspiration; without imaging guidance) or code 10160 (Puncture aspiration of abscess, hematoma, bulla, or cyst), for an aspiration procedure to confirm the presence of pus in the tissues only.

However, most practices would consider the second needle insertion to be making the incision needed to report the I&D code. Given that understanding, the most appropriate code would be 42700 (Incision and drainage abscess; peritonsillar) if draining the abscess was the primary procedure. CPT® does not require that the incision must be made with a scalpel for that procedure.

Standby Time Isn't Applicable to Medicare

Question: A surgeon has requested that our anesthesiologist be on stand-by for a procedure he plans to complete under local anesthesia. He's requesting stand-by because the patient is in her 90s and the family does not want her put to sleep. Can we bill Medicare for the stand-by time?

Answer: You can only bill Medicare for face-to-face time with the patient, so you won't be able to charge for the stand-by time.

Alternative: Some anesthesia groups negotiate a contract rate with the facility for stand-by services. For non-Medicare payers, you can submit 99360 (Physician standby service, requiring prolonged physician attendance, each 30 minutes [e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG]).

Surgeon Needn't Wait for Path Report—But It Helps

Question: Is there a hard-and-fast billing rule that requires us to wait for the pathology report to send out our surgeon's claims?

Minnesota Subscriber

Answer: While there is no hard-and-fast rule that requires you to wait for the pathology report before billing the surgeon's work, doing so is to your advantage. Read on to see three good reasons why you should wait for the path report:

1. Because ICD-9 outpatient coding guidelines state that you should not code a "rule-out" diagnosis, you'll be left coding signs and symptoms if you don't wait for the path report. For instance, if your surgeon performs a breast biopsy, you'll need to report something like 611.72 (Lump or mass in the breast) instead of a specific code such as 174.x (Malignant neoplasm of female breast).

2. The final diagnosis might impact your procedure code. For instance, you'll choose different procedure codes for benign versus malignant lesion removal (such as 11446, Excision, other benign lesion including margins, except skin tag [unless listed elsewhere], face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm, or 11646, Excision,

malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm.).

3. You might lose opportunities to report additional procedures based on pathology. For instance, you can separately report an appendectomy during another abdominal procedure using +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]) if you have documentation (such as a pathology report) indicating a distinct medical need for the surgeon to remove the appendix.