Outpatient Facility Coding Alert

Procedure Spotlight: 3 Steps Help You Determine Whether Modifier 22 Is Merited

Tip: Clues in the op note can give you the boost you need.

Little-known fact: You can't automatically code additional procedures when your surgeon documents an artery exploration and dissection during hand surgery. Dissection of a mass from an artery or nerve is included in the mass excision codes and is not separately reportable.

Check out the following op note, and then determine how you would code the claim before you review our experts' advice below.

Preoperative diagnosis: Right wrist mass, ganglion cyst or aneurysm on the radial artery, and carpal tunnel syndrome.

Procedure overview: The surgeon performed a ganglion cyst excision, radial artery exploration with a radial arterioplasty, radial nerve branch release via neuroplasty, wrist joint arthrotomy and synovectomy, and carpal tunnel release.

Step 1: Follow the Surgeon's Notes

The pertinent details of the op note follow.

We made an incision directly over the mass and carefully dissected it until we found the radial artery right on top of it, and the nerve branch right next to it on the radial side. We approached it from the proximal end and freed up the artery and nerve and carefully dissected them off of the mass. We had to strip the mass off of the artery because they had adhered to one another. The mass came out distally from the proximal wrist joint.

We performed arthrotomy and discovered synovitis, which we excised with a rongeur curette. We irrigated and closed the wound and the capsule.

We then addressed the carpal tunnel and made an incision from the flexor crease of the palm down distally until we exposed the transverse carpal ligament, which we released from proximal to distal under direct vision, median nerve and radial to it. No masses were present on the carpal tunnel floor. We irrigated and closed the wound.

Coding advice: You should report 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel) for the carpal tunnel release and 25111-51 (Excision of ganglion, wrist [dorsal or volar]; primary; multiple procedures) for the mass excision, says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P, Coder on Call, Inc., Milltown**, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA. (Note: You would not report the -51 modifier in the facility setting.)

ICD-9 check: You should link 64721 to 354.0 (Carpal tunnel syndrome) and link 25111-51 to 727.41 (Ganglion of joint).

ICD-10: When October 1, 2014 hits, code 354.0 will expand into three options:

- G56.00 □ Carpal tunnel syndrome, unspecified upper limb
- G56.01 □ Carpal tunnel syndrome, right upper limb
- G56.02 □ Carpal tunnel syndrome, left upper limb.

Code 727.41 will become numerous options (M67.4--, Ganglion), based on site.

Step 2: Decide Whether Dissection Is Separately Billable

Although the physician documented the need to dissect the radial artery and nerve off of the underlying cystic mass, the American Academy of Orthopaedic Surgeons (AAOS) considers exploration of the radial or ulnar arteries and neuroplasty for surgical exposure to be components of the global surgical package of code 25111, Stout says.

Although some physicians feel that the dissection should warrant more money than what Medicare pays for the mass excision, most believe that it's just part of the surgery.

Step 3: Remember This Rare Caveat

"If the surgical dissection was unusually complicated, modifier 22 (Increased procedural services) can be appended to the professional code, Stout says.

What constitutes an "unusually" complicated surgery? Only the surgeon can determine whether a surgery was unusually complicated. For instance, there are some cases that the cyst wraps around the entire artery, and these can be very challenging. Other examples would include if the patient's operative site had such excessive scarring that the surgeon spent significant extra time navigating the site.

Keep in mind: Payers carefully review claims with modifier 22 appended, and most coding experts agree that modifier 22 is only warranted in less than 3 percent of a surgical practice's claims.