CPT® Surgery Coding Guidelines

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Objectives

- Review CPT Surgery Guidelines
- Review CPT Surgical Package
- Surgical Follow Up Care
- Discuss Modifier Usage
- Documentation Requirements for CPT Surgery
- Practice CPT Surgery Case Scenarios

CPT Surgery Guidelines

The guidelines for the use of CPT codes are found as introductory notes at the beginning of a section or subsection, or as cross-references following specific codes or series of codes. Although the information contained in these guidelines is important when using the CPT codes, changes to the guidelines often are overlooked.
History of CPT

- CPT® is Current Procedural Terminology, and was developed by the American Medical Association in 1966.
- January 1, 2007 effective update for CPT.
- The most recent version of CPT, contains 8,611 codes and descriptors.

Rationale for CPT Surgery Guidance

- CPT codes define medical and surgical procedures performed on patients.
  - Some procedure codes are very specific defining a single service (e.g. CPT code 93000 (electrocardiogram) while other codes define procedures consisting of many services (e.g. CPT code 58263 (vaginal hysterectomy with removal of tube(s) and ovary(s) and repair of enterocele).
Polling Question

How frequently is the National Correct Coding Initiative updated?

* 1 Annually
* 2 Bi-Annual
* 3 Quarterly
* 4 Monthly

Guidance for CPT Surgery

- NCCI - National Correct Coding Initiative was developed by CMS to promote correct coding methodologies
- Initially intended for Part B Claims
Guidance for CPT Surgery cont.

- Procedures should be reported with the HCPCS/ CPT codes that most comprehensively describe the services performed.

- Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Documentation Requirements

CPT Surgery

- Operative report
- Technique and approach
- Open vs. closed, aspiration, percutaneous, etc
- Screening vs. diagnostic vs. therapeutic
- Location- Right, left, bilateral, distal, proximal, etc.
Integral Surgery Services

- Some services are integral to large numbers of procedures.
  - Cleansing, shaving and prepping of skin
  - Draping and positioning of patient
  - Insertion of intravenous access for medication administration
  - Sedative administration by the physician performing a procedure
  - Local, topical or regional anesthesia administered by the physician performing the procedure

Integral Surgical Approach

- Including identification of anatomical landmarks,
  - incision,
  - evaluation of the surgical field,
  - simple debridement of traumatized tissue,
  - lysis of simple adhesions,
  - isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
  - surgical cultures
Integral Surgical Approach cont.

- Wound irrigation
- Insertion and removal of drains,
- suction devices, and pumps into same site-
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings including analgesic devices (peri-incisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided.

Unbundling

- Two types of practices lead to unbundling.
  - The first is unintentional and results from a misunderstanding of coding.
  - The second is intentional and is used by providers to manipulate coding in order to maximize payment.
- Correct coding requires reporting a group of procedures with the appropriate comprehensive code.
Polling Question

A patient has a benign lesion on the back and a benign lesion on the thigh that he wants removed. The physician excises the lesion on the back making a 2 cm incision and makes a 1.5 cm incision to remove a .8 cm lesion on the thigh. What are the correct code(s):

* 1  11402
* 2  11402, 11402-59
* 3  11401, 11402

Fragmented Unbundling

• Fragmenting one service into component parts and coding each component part as if it were a separate service:

• For example:
  • The correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate.
Unbundling for Related Services

- Reporting separate codes for related services when one combined code includes all related services:
  - For example:
    - This type of unbundling is coding a vaginal hysterectomy with bilateral salpingo-oophorectomy as a vaginal hysterectomy (CPT 58290) with salpingectomy (CPT code 58700) and oophorectomy (CPT code 58940) rather than using the combined CPT code 58291 which includes all three related services.

Breakout Unbundling

- Breaking out bilateral procedures when one code is appropriate:
  - For example:
    - Bilateral mammography is coded correctly using CPT code 77056 rather than incorrectly submitting CPT code 76055-RT for right mammography and CPT code 76055-LT for left mammography.
**Downcode Unbundling**

- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate:
  - A laboratory should bill CPT code 80048, (basic metabolic panel), when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multi channel tests.
  - It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520 in addition to the CPT code 80048

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**Unbundling Surgeries**

- Separating a surgical access from a major surgical service:
  - For example:
    - A provider should not bill CPT code 49000 (exploratory laparotomy) and CPT code 44150 (total abdominal colectomy) for the same operation because the surgical field is included in the code for the total abdominal colectomy.
Polling Question

How would the removal of a cerumen impaction prior to myringotomy be coded?

* 1 The removal of cerumen impaction would be coded in addition to myringotomy.

* 2 The removal of cerumen impaction would NOT be coded in addition to myringotomy.

* 3 Both procedures would be coded and modifier -59 should be appended to the impaction code.

* 4 Both procedures would be coded and modifier -59 should be appended to the myringotomy code.

Surgical Package Definition

- The following are services typically included in addition to the operation:
  - local infiltration, metacarpal/ metatarsal/ digital block or topical anesthesia;
  - subsequent to the decision for surgery, one related evaluation and management (E/ M) encounter on the date immediately prior to or on the date of the procedure (including history and physical);
  - immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
Surgical Package Definition Cont.

• writing orders;
• evaluating the patient in the post-anesthesia recovery area;
• typical postoperative follow-up care.

Case Study

A patient presents with a pilonidal cyst and an I&D is done and the surgeon decides that it is medically necessary to excise this cyst. It would be appropriate to submit a bill for CPT code 11770 (excision of pilonidal cyst); it would not, however, be appropriate to also report CPT code 10080 (incision and drainage of pilonidal cyst).
Global Surgical Package

- Pre and Post operative care related to surgery is not billable.
  - Minor surgery - 10 days
  - Major surgery - 90 days

Polling Question

Which of the following statements is incorrect in relation to services included in the global surgical package?

*1 Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;

*2 Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;

*3 Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

*4 Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are not related to recovery from the surgery.
Billing during Global Surgical Periods

• To ensure the proper identification of services that are, or are not, included in the global package, the following elements apply:
  • Physician office and facilities
    • Append the appropriate modifiers and procedure codes
    • Include Date(s) of Service
    • Specify if Care Provided in Different Payment Localities

Modifier -51

• Modifier - 51 Multiple Procedures (Physicians)
• For example:
  • If a renal endoscopy is performed through an established nephrostomy, a biopsy is performed, a lesion is fulgurated and a foreign body (calculus) is removed, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.
**Modifier -58**

- Modifier -58 is described as a “staged or related procedure or service by the same physician during the postoperative period.”
- Example:
  - It is recognized that a Mohs’ surgeon may find it necessary to obtain a diagnostic biopsy in order to make the decision to perform surgery. When a diagnostic biopsy is necessary, it may be reported separately. Modifier -58 may be utilized to indicate that the diagnostic biopsy and Mohs’ Micrographic Surgery are staged or planned procedures.

**Modifier -78**

- Modifier 78 - Return to Operating Room
  - Use this modifier when treatment for complications requires a return trip to the operating room.
  - The procedure code for the original surgery is not used except when the identical procedure is repeated.
- Example:
  - A femoral-popliteal nonautogenous bypass graft (35656) is placed. Infection is noted in the lower extremity within the follow-up period (during the 90 days) of the bypass graft. The patient is returned to the operating room for explantation and debridement.
Modifier -59

- Modifier -59 is an important NCCI-associated modifier that is often used incorrectly.
  - Primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.
  - Only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.

Polling Question

A Medicare patient had a medial meniscectomy on the right knee and a debridement on the left knee. Both procedures were done through an arthroscope. Which of the following are the correct codes and modifiers?

*1 29881, 29877-59
*2 29877-LT, 29881-RT
*3 29877-LT, 29881-59-RT
*4 G0289, 29881
**NCCI Edits**

- **National Correct Coding Initiative Edits**
- The CCI edits are incorporated within the outpatient code editor (OCE).
- The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts.
- Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced. The unit-of-service edits determine the maximum allowed number of services for each CPT/HCPCS code.
Separate Procedure

- If a HCPCS/CPT code descriptor includes the term “separate procedure,” the HCPCS/CPT code may not be reported separately with a related procedure.
- CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region through the same skin incision, orifice, or surgical approach.

Add-On Codes

- The CPT coding system identifies certain codes as “add-on” codes which describe a service that can only be reported in addition to a primary procedure.
- CPT Manual instructions specify the primary procedure code(s) for some add-on codes.
- For other add-on codes, the primary procedure code(s) is(are) not specified, and generally, these are identified with the statement: "List separately in addition to code for primary procedure."
Add-On Codes Examples

A patient has 10 lesions removed by electrosurgery. The first lesion is coded 17000. An add-on code is used for the additional 9 lesions with code 17003.

A patient has an open repair of a ventral hernia with mesh. The repair code is 49560 and the additional code for the mesh is 49568.

Polling Question

A patient had an excision of a benign lesion measuring 2 cm on the cheek. The wound was repaired with an adjacent tissue transfer. Which of the following is the correct code?

*1 14040
*2 11442, 13131
*3 14040, 11442
*4 14040, 12051
Multiple Approaches for Surgery

- Multiple approaches to various procedures, are often clusters of CPT codes describing the various approaches
  - (e.g., vaginal hysterectomy as opposed to abdominal hysterectomy).
- Mutually exclusive procedure
- Endoscopic procedures
  - When an endoscopy represents a distinct diagnostic service prior to an open surgical service and the decision to perform surgery is made on the basis of the endoscopy, a separate service for the endoscopy may be reported. Modifier -58 may be used to indicate that the diagnostic endoscopy and the open surgical service are staged or planned procedures.

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Extensive Procedure

- The procedure viewed as the more complex would be reported:
  - "Simple" and "complex" CPT codes reported; the simple procedure is included in the complex procedure at the same site.
  - "Limited" and "complete" CPT codes reported; the limited procedure is included in the complete procedure at the same site.
  - "Simple" and "complicated" CPT codes reported; the simple procedure is included in the complicated procedure at the same site.
Extensive Procedure cont.

- The procedure viewed as the more complex would be reported:
  - "Superficial" and "deep" CPT codes reported; the superficial procedure is included in the deep procedure at the same site.
  - "Intermediate" and "comprehensive" CPT codes reported; the intermediate procedure is included in the comprehensive procedure at the same site.
  - "Incomplete" and "complete" CPT codes reported; the incomplete procedure is included in the complete procedure at the same site.
  - "External" and "internal" CPT codes reported; the external procedure is included in the internal procedure at the same site.

Sequential Procedure

- Initial approach vs. second procedure
  - Second procedure performed due to the initial procedure being unsuccessful.
  - Most invasive service should be reported.
- Example:
  Failed laparoscopic cholecystectomy followed by an open cholecystectomy at the same session.
Sources of Information

- National Correct Coding Initiative Policy Manual for Medicare Services
  http://www.cms.hhs.gov/NationalCorrectCodInitEd/
- CPT-4 2007 published by AMA
- Medicare Claims Processing (PUB. 100-04) Chapter 12 - Physicians/ Nonphysician Practitioners
  40 - Surgeons and Global Surgery
- CPT Assistant published by AMA

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