Coding and Documentation for Minor Procedures

My Background

- My connection to coding and documentation

- My connection to clinical processes

- My connection to ICD-10

- My connection to YOU

Disclaimer

The information provided within this presentation is for educational purposes only and is not intended to be considered legal advice. Opinions and commentary are solely the opinion of the speaker. Many variables affect coding decisions and any response to the limited information provided in a question is intended to provide general information only. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation, medical necessity, hospital bylaws, state regulations, etc. The CPT codes that are utilized in coding are produced and copyrighted by the American Medical Association (AMA).

Agenda

- Discuss what is included in the global surgical package

- Outline the difference between a major and minor procedure

- Determine when the global period starts and ends

Global Surgical Package

- Consists of all necessary services performed by the provider before, during and after a surgical procedure.

- Medicare payment includes all applicable preoperative, intra-operative, and postoperative services, including care due to complications from the surgery.

Global Surgical Package

- Preoperative Visits:
    - Preoperative visits begin with the day before the surgery for major procedures and the day of the surgery for minor procedures.
    - Includes all visits related to the surgery, in or out of the hospital, on the day of the surgery.

- Intraoperative Services:
    - Services that are normally a usual and necessary part of the surgical

Global Surgical Package

- Complications Following Surgery:
  - Include all additional medical or surgical services required of the surgeon during the postoperative period of the surgery due to complications **that do not require additional trips to the operating room**

- Postoperative Visits:
  - Follow-up visits during the postoperative period that are related to recovery from the surgery.

Global Surgical Package

- Other Services:
  - Dressing changes, local incision care, removal of operative pack, sutures, staples, lines, wires, tubes, drains, casts, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

What's NOT included in the Global Package

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.
    - Applies to major surgical procedures (90 day global). Report the E/M code with modifier 57.
    - The initial evaluation is always included in the allowance for a minor surgical procedure.

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care.

Polling Question

- Only hospital procedures are considered major procedures so in the clinic we would never need to append modifier 57 to an E/M code since modifier 57 is used to indicate an E/M service resulted in the decision to perform the major procedure?

    - True
    - False

What's NOT included in the Global Package

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications from the surgery.

- Postoperative complications that require a return trip to the operating room.

- Treatment for an underlying condition or an added course of treatment that is not part of the normal recovery from surgery.

What's NOT included in the Global Package

- Diagnostic tests and procedures, including diagnostic radiological procedures.

- Clearly distinctive surgical procedures during the postoperative period that are not repeat operations or treatment of complications. In this case, follow the CPT code with modifier XX.
    - A new postoperative period begins with the subsequent procedure.

- Evaluation and management (E&M) services unrelated to a surgical procedure.

Major versus Minor Surgical Procedures

- The difference between major and minor surgical procedures is reflected in the number of follow-up (postoperative) days after the surgery.

Determining the Global Period

- To determine the global period for major surgeries, count 1 day immediately before the day of surgery and the 90 days immediately following the day of surgery.

- To determine the global period for minor surgeries, count the day of surgery and the appropriate number of days immediately following the day of surgery.

Documentation

- Accurate and complete
  - Should paint a picture of the patient's encounter

- Only documented services should be coded

- The documentation is the key to correct code assignment and appropriate reimbursement

- Does the documentation support not only the code(s) assigned, but also medical necessity

Wording

- Quantity
  - Each, each additional
  - Up to xxx
- Severity
  - Simple, complex, extensive
- Inclusive
  - With or without
- Site
- Size
- Depth
- Method – incision, excision, biopsy, etc.

Choices

- Paring/cutting benign hyperkeratotic lesion - 11055-11057

- Biopsy -11100-11101

- Removal of skin tags -11200-11201

- Shaving - 11300-11313

Choices

- Excision benign skin lesions
  - Trunk, arms, legs - 11400-11406
  - Scalp, neck, hands, feet, genitalia -11420-11426
  - Face, ears, eyelids, nose, lips, mucous membrane - 11440-11446

- Excision skin, and subcutaneous tissue, hidradenitis
  - Axillary - 11450-11451
  - Inguinal - 11462-11463
  - Perianal, perineal, umbilical - 11470-11471

- Excision malignant skin lesions
  - Trunk, arms, legs - 11600-11606
  - Scalp, neck, hands, feet, genitalia - 11620-11626
  - Face, ears, eyelids, nose, lips - 11640-11646

- Destruction
  - benign or premalignant lesions - 17000-17250
  - malignant lesions – 17260 - 17286

Integumentary

- Be careful to code based on the actual procedure performed:
  - Destruction of premalignant/benign lesions (add-ons)
  - Biopsy
  - Incision
  - Excision (remember to include margins...)
    - Benign
    - Malignant
  - Destruction
  - Repair
  - Breast procedures are located in a separate section

Integumentary

- An E&M service reported on the same day as a dermatological surgery is subject to the Medicare global surgery rules and will only be payable if a significant and separately identifiable medical service is rendered and clearly documented in the patient's medical record.

- Modifier-25 should be appended to the appropriate visit code to indicate the patient's condition required a significant, separately identifiable visit service in addition to the procedure that was performed.

Lesions, lumps, bumps….

- ## What is it?
  - Abscess, lesion, cyst….?
  - Bone cyst or spur…?
  - Plantar neuroma or wart, …..?
- ## Where is it?
- ## How low did you go?
  - Depth- skin, sub-Q, muscle, ?..
- ## What exactly was done?
  - Biopsy, excise, shave…
- ## Type of repair?
- ## Documentation is crucial!

Biopsy/Shave Confusion

- A biopsy is done to evaluate a suspicious lesion in which your physician may not want to completely excise. There are several methods that can be used for a biopsy.

- A shave is defined by CPT® as the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision.

Location of Biopsy

- Biopsy skin, subcutaneous tissue…
  - 11100 for your first lesion
  - +11101 of each additional (add-on code)

- Biopsy of eyelid - 67810

- Biopsy of cervix - 57500

- Biopsy of external ear - 69100

- Biopsy intranasal - 30100

- Biopsy of lip – 40490
  - *All codes include a simple closure*

Shave

- Shaving of epidermal or dermal lesion

- Codes 11300 – 11313 – based upon anatomic location and size

- Sharp removal by transverse incision or horizontal slicing

- Without full thickness, dermal excision

- No sutures required

Skin Tags

- Skin Tag Removals
    - 11200 (up to and including 15)
    - +11201 (each additional 10 lesions, *or part thereof*)

- Removal with scissors or any other method including electrosurgical destruction or combination, including chemical or electrocauterization, with or without local anesthetic

Destruction

- 17000, 17003, 17004 – premalignant
  - Make sure diagnosis is accurate

- 17110 and 17111– benign any method

- 1726x - malignant based on anatomic location and excised diameter

Medical Necessity

- If a beneficiary wishes to have one or more benign asymptomatic lesions removed that pose no threat to health or function, and for cosmetic purposes:

  - The physician should explain to the patient, in advance, that Medicare will not cover cosmetic cutaneous surgery and that the beneficiary will be liable for the cost of the service. Charges should be clearly stated. A claim for cosmetic services does not need to be submitted to the Medicare Contractor, unless the patient requests that the claim be submitted on his/her behalf.

  - When the patient requests the claim for cosmetic services be submitted on his/her behalf, the services should be reported with modifier GY (items or services statutorily excluded or does not meet the definition of any Medicare benefit) **and** diagnosis code **Z41.1**.

Incision and Drainage

- CPT codes 10040-10180

- Definition:
  - A surgical procedure whereby an incision is made in the tissue to drain a fluid or pus filled cavity.

Incision and Drainage

I & D of abscess or cyst – simple 10060, or complex 10061?

- Complex usually involves packing and/or drains, possibly infection, amount of bleeding or depth of wound. The physician should determine if simple or complex.

  (remember global days)

- If a cyst is removed refer to "excision" codes 114XX

- If layered suture repair is required, look at additional codes

Hematoma, Seroma, Bulla, Cyst

- CPT code 10140 - Incision and drainage of hematoma, seroma or fluid collection

- CPT code 10160 - Puncture aspiration of abscess, hematoma, bulla, or cyst

Debridement

- CPT codes 11000-11047 and 97597-97598

- Definition:
  - A term of French origin from the removal of necrotic, infected or foreign material from a wound

Debridement's

- These codes maybe subject to **LCD's:**
  - 11042 Skin, Subcutaneous Tissue
  - 11043 Skin, Subq , Muscle
  - 11044 Skin, Subq , Muscle, Bone

- These codes are reported by size (in sq cm) and there are add-on codes in addition to the codes above.

CPT codes 97597 and 97598,

- "to remove devitalized and/or necrotic tissue and promote healing"
- 97597 Selective debridement, without anesthesia – wound area <20 sq cm
  - High pressure water jet
  - Sharp selective debridement (scissors, scalpel and forceps)
- 97598 Wound area > 20 sq cm

- Check LCD

CPT code 97602

- Non-selective debridement without anesthesia
    - Wet to moist dressings
    - Enzymatic
    - Abrasion

Documentation is crucial

- Medical diagnosis and indications
- Type of anesthesia used, if applicable
- Level or depth of tissue debrided
- Wound characteristics (i.e. diameter, color, presence of exudates or necrotic tissue)
- Vascular status
- Clear concise documentation of the procedure
- Patients response to treatment
- Patient specific goals

Paring and Cutting

- CPT codes 11055 – 11057
- Definition:
  - To cut or pare off from the surface of a body with a razor or other edged instrument; to cut off closely
- For removal or corns and callus
- Documentation must support the number of lesions for billing
- Check LCD

Paring and Cutting

- Code is based upon the number of lesions:

  - 11055 – single lesion
  - 11056 – 2-4 lesions
  - 11057 – more than 4 lesions

Pilonidal Cyst

- CPT codes 11770-11772

- Definition:
  - A special kind of abscess that occurs in the cleft between the buttocks. Forms frequently in adolescence after long trips that involve sitting
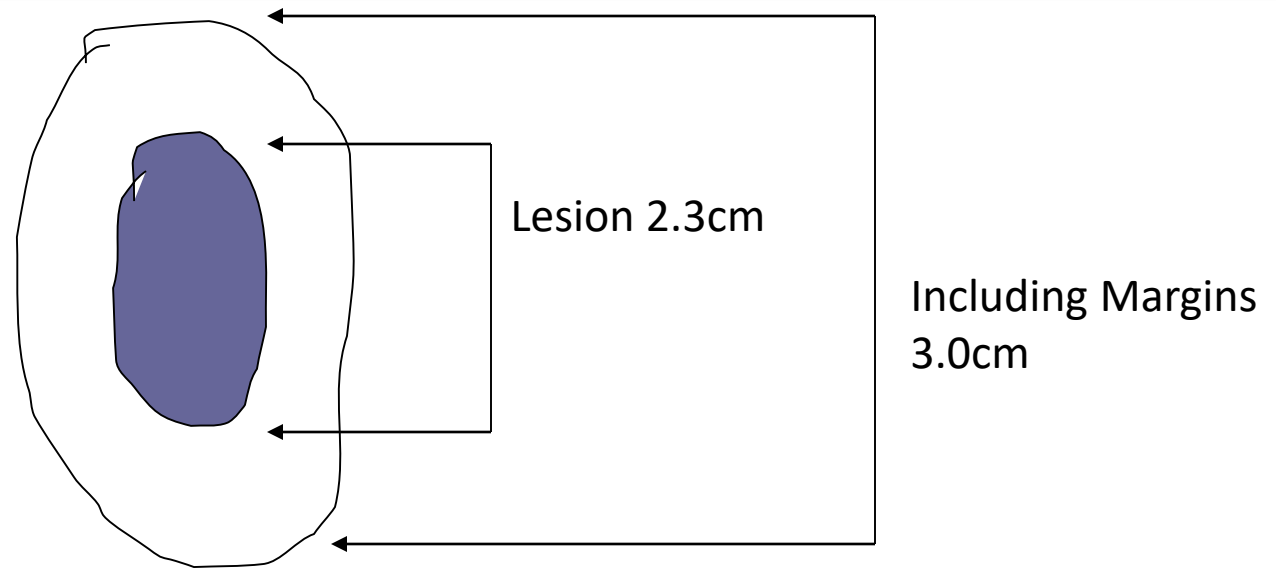
Lesions

- Benign
  - 114XX – anatomical location

- Malignant
  - 116XX – anatomical location

- Remember DON'T add lesion excisions together

Lesions

- Determine the type of treatment:
  - Destruction
  - Excision
  - Biopsy
  - Shave

- Measurement instructions for excisions are found in CPT. **Include the margins removed.** Be <u>precise</u> in the measurement

Measuring Lesions

Lesion 2.3cm

Including Margins 3.0cm

Lesions

- Documentation must include

    - Size
    - Location
    - Number of lesions removed

Lesions

- Full thickness, through dermis removal of lesion

- If more than one lesion is excised, each lesion should be reported separately

- Includes simple (non-layered) closure

Foreign Body Removal

- Incision and removal of foreign bodies is reported with 10120 or 10121.
    - **An incision is required to use these codes.**

- Removal with forceps is included in the E/M visit.
    - *be careful in using CPT index, "foreign body" leads you to higher complexity codes.*

Repair

- 3 types of repairs:

    - Simple (12001 –12021)
        - Superficial, epidermis or dermis

    - Intermediate (12031 –12057)
        - Layered, deeper layers of sub-q tissue

    - Complex (13100 –13160)
        - Scar revision, debridement, undermining

Simple Repair

- Used when the wound is superficial. Typically involves the epidermis or dermis without significant involvement of the deeper structure of the skin.

  - ONE layer closure

Intermediate Repair

- Require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin closure

  - OR

- Single layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes the use of Intermediate Repair codes.

Complex Repair

- Wounds such as scar revision, debridement, extensive undermining, stents, or retention sutures. Necessary preparation includes creation of a defect for repairs or the debridement of complicated lacerations or avulsions.

Repairs

- Add together if the repair is in the same anatomical location and same type of repair

    - Example: Complex repair on cheek 1.2 cm and on mouth 2.1 cm
        - Report CPT code 13132 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6cm to 7.5cm

Laceration Repairs

- Documentation requirements:
  - Size (2.5 vs. 2.6 will increase payment). Without the size documented, down code to the smallest size, or the 1st entry in that category.

- Location (will increase payment for facial, etc)

- Type of closure (simple, complex)

- Dermabond is considered a simple repair

Common Problems

- Size or the number of lesions (skin tags for example) not documented

- Missed layered closure

- Physician states "biopsy" when the procedure was an <u>excisional</u> biopsy.

- Biopsies of additional lesions do not include modifier -59.

Polling Question

- CPT code 69210 - Removal impacted cerumen requiring instrumentation, unilateral is billable ONLY if performed by a physician or non-physician practitioner (i.e. NP, PA, etc.).?

    - True
    - False

Cerumen Impaction Removal

- CPT code 69209 - Removal impacted cerumen using irrigation/lavage, unilateral

- CPT code 69210 - Removal impacted cerumen requiring instrumentation, unilateral

Cerumen Impaction Removal

- Visual considerations – cerumen impairs the exam of clinically significant portions of the external auditory canal, tympanic membrane or middle ear.

- Qualitative considerations – when the cerumen is extremely hard, dry and irritating the ear causing symptoms such as pain, itching and hearing loss, etc.

- Inflammatory considerations – cerumen is associated with foul odor, infection, or dermatitis.

- Quantitative considerations – obstructive, copious cerumen that cannot be removed without magnification and instrumentation requiring physician skills.

CPT code 57454

- Colposcopy of the Cervix (including adjacent/upper vagina), with biopsy of cervix AND ECC.

- Pre-Op: Positioning, prepping and draping, etc.

- Intra-Op: Speculum, enhancing medium, exam, biopsy, ECC, hemostasis, local.

- Post-Op: Dressing/Packing, evaluation/stabilization, dictation, review of pathology report, completion of patient record, instructions to patient, consultation with family.

Minor Procedures

- Know the codes available

- Document a procedure note

- Determine if there is a LCD or NCD

Medicare Payment G Codes

- G0466 – FQHC visit, new patient

- G0467 – FQHC visit, established patient

- G0468 – FQHC visit, IPPE or AWV

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Ms. Sulzberger is a Licensed Practical Nurse, Certified Professional Coder and ICD-10 Trainer. She received her Bachelors of Science degree in Business Administration from Mid America Nazarene University. Ms. Sulzberger received her nursing license in 1994 and was a practicing clinician at Saint Luke's Health System for several years before transferring to the internal compliance/audit area. She became credentialed as a Certified Professional Coder in 1996 and assisted the Saint Luke's Health System with performing medical record chart audits to verify the accuracy of the internal coding and claims processing.

Ms. Sulzberger spent approximately six years as a coding/billing consultant with National accounting and consulting firms (BKD, Grant Thornton) before becoming the President of Coding & Compliance Initiatives, Inc. (CCI) in April 2003. Ms. Sulzberger assists her clients with improving their operational performance in a variety of critical outcome areas, including coding/billing, corporate compliance, charge capture processes, etc. Ms. Sulzberger works with a variety of health care providers including hospitals, physician practices, and rural health clinics in their daily compliance and operational activities.

Ms. Sulzberger presents locally and nationally on coding topics as well as developing specialized training programs to meet the needs of her clients. Shellie recently was credentialed through American Institute of Healthcare Compliance as a Certified ICD-10 Trainer.