

Don't Be Obstructed By Colon Surgery

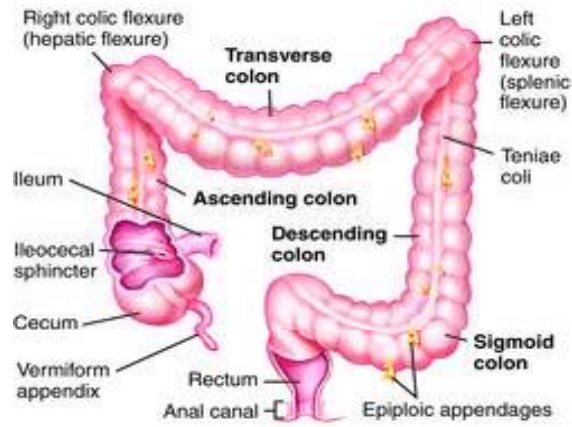
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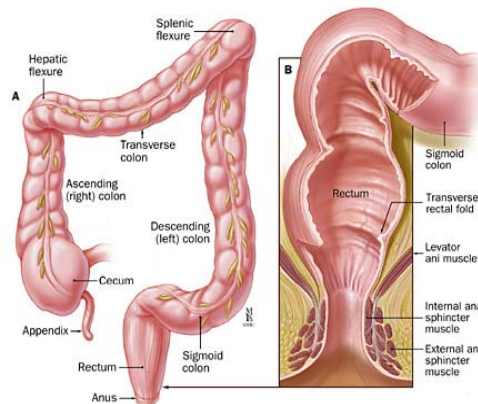
Objectives

- Understand anatomy for bowel procedures
- Understand the terms related to surgery of bowel
- Medical Necessity and You
- ICD-9 to ICD-10 Are you ready??
- Gain understanding of procedures and differences between them
- Review op notes

Anatomy



Anatomy



Anatomy

Right side – ileocecal valve, ascending colon

To hepatic flexure – curve of large bowel on the right side of the body, ascending to transverse.

To the Transverse Colon – moving horizontally across the abdomen

To the splenic flexure – curve of the left side attaching transverse and descending colon

Left side – descending colon to sigmoid to rectum and finally anus

Anatomy

3-D lets review and answer questions

What is mesentery??

Mesentery –

Supporting membrane: a membrane that supports an organ or body part, especially the double-layered membrane of the peritoneum attached to the back wall of the abdominal cavity that supports the small and large intestine

Medical Necessity

Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

Medical Necessity

Consider that CMS (formerly HCFA) has the power under the Social Security Act to determine if the method of treating a patient in the particular case is reasonable and necessary on a case-by-case basis. Even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national coverage policy, a local medical policy or a clinically accepted standard of practice.

Medical Necessity

Consider any NCD or LCD for medical necessity.
LCD will change with regions/MAC's

Medical Necessity

“ Medicare carrier and fiscal intermediary Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) succinctly define medical necessity requirements.

Covered diagnoses, documentation requirements, and limitations of coverage for specific services are also included in the many promulgated LCDs and NCDs that serve as a roadmap for a provider’s establishment of medical necessity.

Despite these guidelines, challenges continue to surface regarding how to establish medical necessity. Ultimately, a physician’s clinical judgment is the guiding principle behind the appropriateness of medical necessity when it comes to inpatient versus outpatient observation designation. “

Glenn Krauss/HCPPro

ICD-9 to 10

- Neoplasm
- Obstruction
- Intussusception
- Stricture
- Perforation
- Complications from some other source

Compare, You Ready??

ICD-9

- Neoplasm – 153 – 154 – stated or presumed primary
 - Neuroendocrine tumor – 209
 - **Code First** any multiple endocrine neoplasia syndrome (258.01 -.03)
 - **Use Additional** code for assoc endocrine syndrome i.e.(259.2)
 - Metastatic to Nodes – 196 – secondary by location

ICD-10

- Neoplasm -C18, C19, C20, C21
 - Neuroendocrine tumor – C7a.xxx
 - **Code First** any multiple endocrine neoplasia syndrome (E31.2x)
 - **Use Additional** code for assoc endocrine syndrome i.e.(E34.0)
 - Nodes – metastatic – C77.x

ICD-10

- Additional coding
 - Crohns Disease category has been expanded, includes the complication, i.e. obstruction, bleeding K50.xxx
 - Asking for you to code manifestation, if known
 - Same expansion for Ulcerative Colitis – K51.xxx
 - Other disease and disorder – K55, K56, K57, K58, K59

Clear documentation is the key to this transition



Modifiers

- -22
- -59
- -76 - -77
- -78 - -79
- -80 - -AS

How do we apply these?

What documentation should be there for support?

-22

- CPT states the “documentation must support additional work(increased intensity, time, technical difficulty of procedure, severity of condition and physical/mental effort required”

What will this look like in a note?

Are you savvy enough to guide your physician in documentation of this?

Examples of -22

- “Adhesiolysis was performed for 2 hours due to the patients prior abdominal surgery. The abdomen was like concrete and required tedious lysis so as to be careful not to injure the bowel.”
- “An extended right colectomy was done, this required going beyond the hepatic flexure and into the transverse colon to get a good margin.”

-22



"Your surgery lasted 5 hours, but I'm charging you for 8 hours. I was stuck in traffic for 3 hours on my way here this morning."

-59

- Know your CCI edits
 - Do you understand how to use this?
 - Column's 1 and 2
- Don't be afraid to use it!
- www.cms.gov/medicare/nationalcorrectcoding

CCI

The National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI **code pair edits** are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

How to use CCI

If a provider submits the **two codes** of an edit pair, **the Column 1 code is eligible for payment** and the **Column 2 code is denied**. However, **if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment.** Supporting documentation must be in the beneficiary's medical record.

Modifier Indicator

- **MODIFIER INDICATOR/DEFINITION**
- 0 - (Not Allowed) There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
- 1 - (Allowed) - The modifiers associated with NCCI are allowed with this code pair when appropriate.
- 9 - (Not Applicable) - This indicator means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.

Modifier -59

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

-59 and Diagnosis

Use of modifier -59 to indicate different procedures/surgeries **does not require a different diagnosis** for each HCPCS/CPT coded procedure/surgery. **Additionally, different diagnoses are not adequate criteria for use of modifier -59.** The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

Terms

- -ostomy – a new permanent opening
- -ectomy – surgical removal (excision)
- -itis - inflammation
- Anastomosis – suture tubular structures together
- Lysis – destruction/freeing/breakdown
- Proximal – closest to point of origin
- Distal – farthest from

Approach

- Open
- Laparoscopic
- Davinci
- Percutaneous

– What about “hand assisted?” – thoughts??

The Procedures



Colectomy Codes

44140 – Open - resection of a segment of colon with an **anastomosis** between the **proximal** and **distal** ends

44204 – Laparoscopic approach – same procedure

Colectomy

44141 –

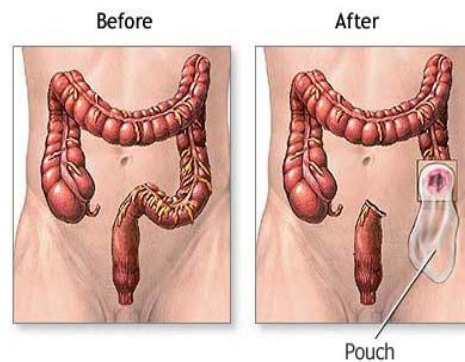
Area of Colon is selected and divided both proximally and distally with diseased segment removed. The proximal end is brought out through the abdomen for a colostomy or an anastomosis done and a loop colostomy performed proximal to the anastomosis.

Partial Colectomy

44143 – (Hartman Procedure)

Resection of colon, brings the **proximal** end of the colon out through the abdominal wall onto the skin as a **colostomy**. The **distal** end is closed with staples or sutures and left in the abdomen.

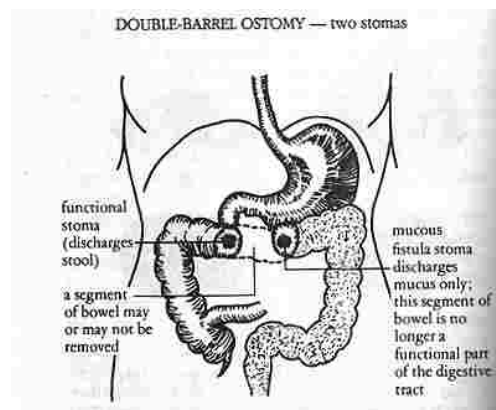
Hartman Pouch



Partial Colectomy

44144 – mucous fistula – not done much anymore, since the creation of the Hartman procedure (44143) was done for the same reason (diverticulitis) in this procedure the diseased colon is resected and BOTH ends **proximal and distal**, are brought out through the abdominal wall onto the skin as a “double barrel” **colostomy**.

Mucous fistula/Double barrel Colostomy



Partial Colectomy

44145 – coloproctostomy – low pelvic anastomosis – resection of **distal** colon or rectum, then creates an anastomosis of the **proximal** colon and the remaining rectum **low** in the pelvis, with staples or sutures.

Partial Colectomy

44146 - coloproctostomy – low pelvic anastomosis – resection of **distal** colon and/or rectum, then creates an anastomosis of the **proximal** colon and the remaining rectum **low** in the pelvis, with staples or sutures. Finally, an area proximal to the anastomosis is chosen for Loop colostomy, usually temporary while the anastomosis heals.

Partial Colectomy

44147

Combined **abdominal** and **transanal** approach, surgeon begins with abdomen, mobilizes the distal colon and rectum. Continues the dissection from below, transanal. The diseased portion removed and an anastomosis between the two ends is performed.

Add on Code

+ 44139 – **Mobilization** (take-down) of **splenic flexure** with partial colectomy

(use in conjunction **with 44140-44147**)

Attachments are dissected free and “taken down” to freely move the colon. This adds in a later, “tension free” anastomosis.

Partial Colectomy

44160 – removal of a segment of the **colon (right side or ascending)** and the **terminal ileum** and performs an **anastomosis** between the remaining ileum and colon. Thus a right colectomy.

Total Colectomy

44150 / 44151 – removal of entire colon, without rectum....

44150 – then creates an ileostomy (Brooke), OR a ileoproctostomy (anastomosis between small bowel and rectum)

44151 – with continent ileostomy (Kock)

Total Colectomy

44155/44156/44157/44158 –

44155 - Abdominal excision/removal of the entire colon and rectum(proctectomy)...the distal rectum is removed through a perineal approach. The terminal ileum is brought out through abdomen for ileostomy.

44156 – forms a pouch with a valve with ileum (Kock)

Total Colectomy

44157 –

Excision of the entire colon as well as rectum and strips the mucosa (membrane that lines the GI tract) from the distal rectum. Anastomosis is then made from ileum, below the sphincter, to the anus. This procedure may also have a loop of ileum, proximal to the anastomosis, brought out to the abdomen as a loop ileostomy.

Why mucosectomy??

Allows the physician to remove all of the colon, while preserving the sphincter on a patient that is at risk for cancer in the colon mucosa

Total Colectomy

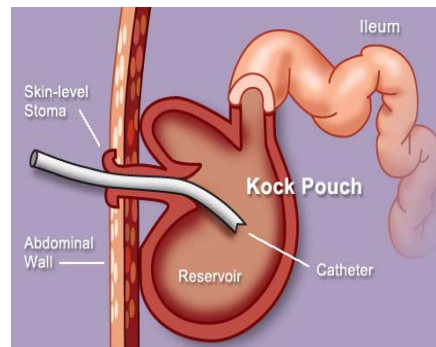
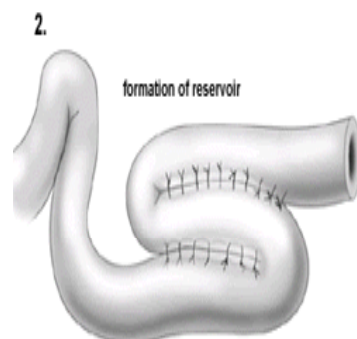
44158 –

Again, all colon and rectum are removed, mucosectomy may be performed. In this procedure the ileum is folded onto itself forming a pouch. That pouch then pulled down through the sphincter and approximated (sutured) to the anus. As with 44157 a loop ileostomy may be done also.

Knowledge Shot!

A word about continent ileostomy(no appliance/bag)..Dr. Kock described this procedure in 1969. 50% failed this treatment. This ostomy leaked and caused issues for the patient. Modifications were made and another doctor (Barnett) went on to improve this procedure, but still there are issues and therefore not widely done anymore. (Won't your Dr's be SO impressed when you can discuss this??)

Kock Pouch Formation



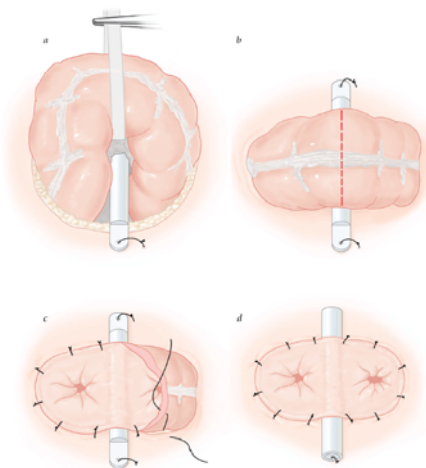
Colostomy or Skin Level Cecostomy

44320 –

Colostomy or skin level cecostomy

Abdominal incision is made, peritoneum is entered, the distal end of the bowel is brought out through the abdomen, and matured as a colostomy

Loop Colostomy



Revisions

44340/44345 –

The stoma is dissected free of any scar tissue, stoma is reapproximated to the skin. May have additional colon pulled through with distal portion transected for revision.

44345 – is a revision with the site changed, involving complete take-down, with closure of initial site

Revisions

44346 –

Repair of paracolostomy hernia. Colostomy is taken down, via an abdominal incision. The hernia is repaired, and the end of the colon is, once again, brought out through a new site for a revised colostomy formation.

Paracolostomy/stomal hernia



Meckel's

Definition - A Meckel's diverticulum is a pouch on the wall of the lower part of the intestine that is present at birth (congenital). The diverticulum may contain tissue that is identical to tissue of the stomach or pancreas.

Approximately 2% of the population has a Meckel's diverticulum, but only a few people develop symptoms.

Meckel's Diverticulum



Meckel's diverticulum

44800 – Via an abdominal incision, the Meckel's diverticulum is located in the terminal ileum. It is then excised and the defect closed with suture or a stapling device. May also be done by transecting and anastomosis. There can also be a communication (omphalomesenteric duct) between the umbilicus and the terminal ileum, which would be excised and repaired in the same fashion.

Appendix

44950/44970 – appendix is mobilized, blood supply divided and appendix transected. Laparoscopic is stapled, open - appendicele stump can be boved/tied or tucked and sutured.

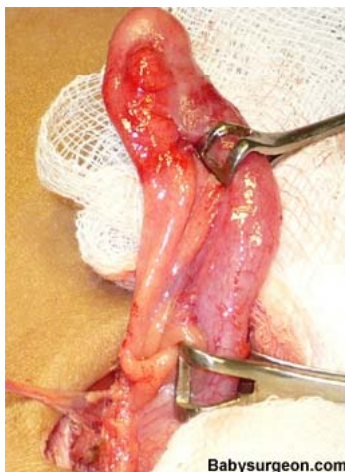
+44955 – When done for indicted purpose at time of other major procedure (have path to support)

44960 - Open unique to rupture – No Laparoscopic equivalent

Incidental

- What was the intent
- Did we know there was disease
- Is there pathology to support
 - These are all questions that should be asked when an incidental appendectomy is performed
 - If you can support it, then you can bill it!

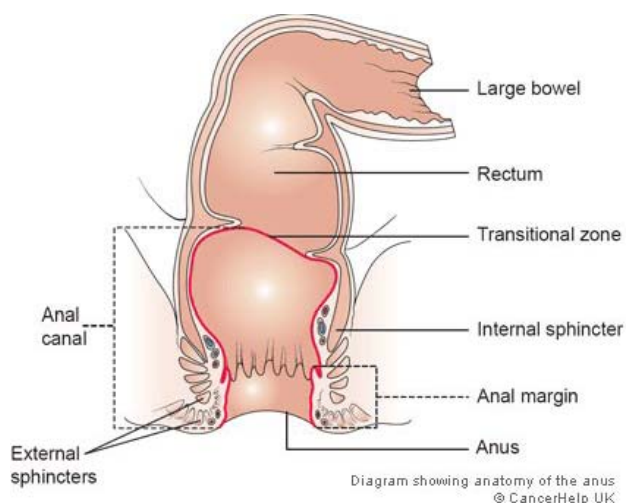
Acute Appendicitis



Abdominoperineal Resection (APR)

- Procedure for rectal or rectosigmoid junction cancer.
- Involves removal of the rectum
- With or Without colostomy

APR Anatomy



APR

45110 –

Abdominally, the **proximal rectum** is mobilized to the level of the **anal sphincter** muscles. The **colon** is divided above the **pelvic brim**.

Attention is then turned to the **perineum**, where the **anus and distal rectum** are dissected free and removed. The **proximal colon** is then brought out through the abdomen as a **colostomy**.

Repairs

- Suture for injury or perforation – colorrhaphy
- Hernia
- Strictureplasty
- Closure of ostomy sites
- Fistula repair
- prolapse

Colorrhaphy

44604 –

Suture repair of wound, perforation, ulcer, single or multiple without colostomy(no resection)

44605 –

Same procedure, with colostomy formation

Omentum

+49905 –

Omental flap, intra-abdominal (List separately in addition to code for primary procedure)

An example might be using this in the repair of a colo-vesical or colo-vaginal fistula. The omental flap would act as a barrier, to prevent recurrence of fistula formation.

Strictureplasty

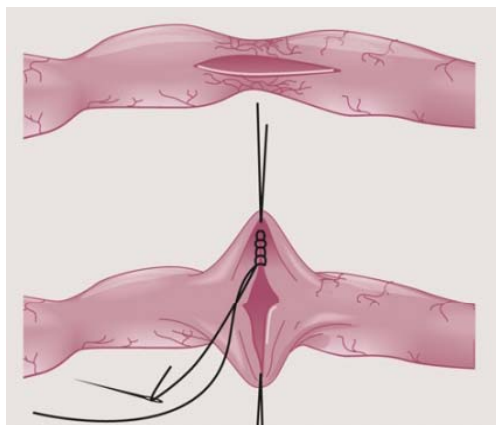
44615 –

Surgeon locates area of stricture via an abdominal incision, area is incised in a longitudinal manner. Area may need dilatation.

The area is then repaired transversely.

Crohn's patients are classic for this procedure

Strictureoplasty



Ostomy Closure

44620/44625/44626 –

Ostomy closure is the take down of the ostomy, whether large or small bowel. The code will change if there is resection, other than, colorectal(44625) or with colorectal anastomosis(44626) closure of Hartman type procedure.

Fistula Repair

44640/44650/44660

What is communicating?

Skin and bowel, bowel to bowel, or bladder to bowel?

In this procedure the surgeon will identify the area that is communicating, the bowel resected in the area of the fistula with anastomosis done and closure of both defects.

Fistula

44660/44661 –

For this procedure the bladder is involved. These codes change whether the intestine and/or bladder need to be resected to get proper repair.

Proctopexy

Done for prolapse, usually elderly

Codes are both laparoscopic and open approach

May be done with resection of sigmoid colon

Proctopexy

Open Approach

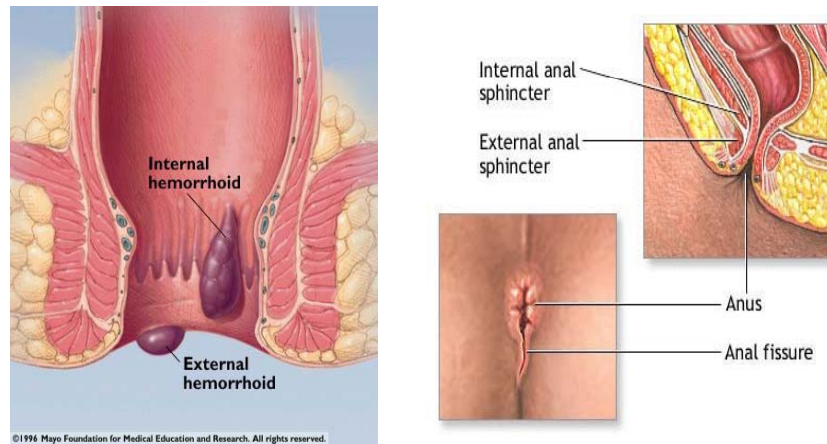
45540 – abdominal approach – rectum is pulled up and attached to sacrum. Mesh may be used.

45541 – perineal approach – same procedure, different approach through levator muscle, slack taken up, approximated to sacrum with or without mesh

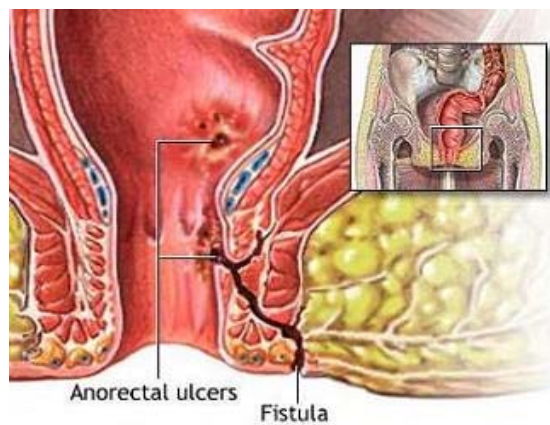
45550 – same as a 45540, with resection of sigmoid colon

(laparoscopic 45400/45402)

Hemorrhoid Surgery



Anal Fistula



Hemorrhoid Surgery

Hemorrhoid surgery is basically varicose vein surgery in the rectum. There are 3 primary columns that are affected with hemorrhoids. Left lateral, right anterior and right posterior. Hemorrhoids can be either internal, within the anal canal or external, at the anal opening. External are painful and problematic. Internal are only problematic if they prolapse or bleed.

Hemorrhoidectomy

When coding for hemorrhoids, you need to consider method of treatment (rubber band, surgical excision or stapling device or ablation)
Also are the hemorrhoids internal or external?
How many columns are being treated?
Was fissure or fistula addressed at the same time as hemorrhoid surgery?

Hemorrhoidectomy

46221 – **internal**, rubber band ligation(s)

46945/46946 – **internal**, ligation other than rubber band, 1 column or 2 or more columns

46320 – **external**, excision of thrombosed

46250 – external, hemorrhoidectomy, 2 or more columns

(**Note – if only one column is addressed CPT directs you to use the unlisted code 46999**)

Hemorrhoidectomy Combined Internal and External

46255 – single column/group

46260 – 2 or more columns

Hemorrhoidectomy
Combined Internal and External

46257 – single column/group with fissurectomy

46261 – 2 or more column/groups with
fissurectomy

Hemorrhoidectomy
Combined Internal and External

46258 – single group/column with fistulectomy,
including fissurectomy when performed

46262 – 2 or more columns with fistulectomy,
including fissurectomy when performed

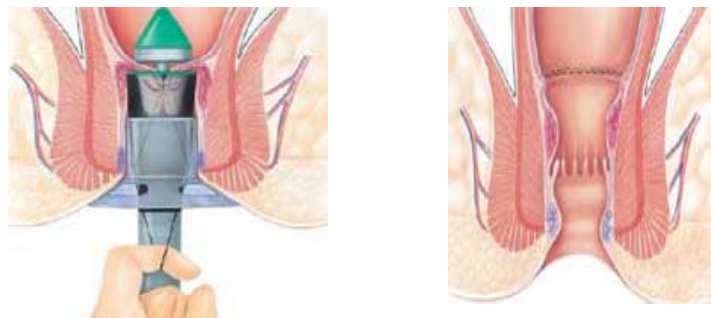
Hemorrhoidopexy

Since we learned that internal hemorrhoids are rarely known, unless they prolapse or bleed, there is now a way to take the prolapse and return it to its appropriate location.

46947 – hemorrhoidopexy, by stapling

Hemorrhoidopexy

PPH



Colon Surgery

Lets look at some notes and code!

THANK YOU!!!
Questions??

