Surgical Coding Errors & English 101

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INTRODUCTION

Many surgical coding mistakes result from misinterpretation of CPT (Current Procedural Terminology) wording. When the CPT Editorial Panel works on a code description, significant time is spent dissecting each word used. Unfortunately, most people attempting to code procedures are not privy to this process – thus, the lack of understanding the intent for which the code is to be used.

This paper presents some of the more common errors encountered in audits of physician and ASC surgical coding.

CPT RULES

CPT specifically states in the *Instructions for Use of the CPT Codebook* "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. In surgery it may be an operation…"

Some of the worst surgical coding advice given in courses and chat rooms that starts with " You can try this and see if you get paid" or "Consider using …" or "I got paid using…". You cannot arbitrarily use another code if it does not describe what was performed. The mistakes resulting from this type of erroneous suggestion is compounded by lack of basic comprehension of the English definitions and how they are used in a coding context.

Getting paid means just that – you were paid. Medicare or other insurers can and do come back and recoup the payment.

Well meaning advice, trying to be helpful, can result erroneous coding and loss of revenue money as well as being audited. If there is not a code for what is being performed, then use the unlisted code.

The following are the most common unlisted codes use in ophthalmology and ophthalmic plastic surgery:

- 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue
- 21499 Unlisted procedure, musculoskeletal procedure, head

- 64999 Unlisted procedure, nervous system
- 66999 Unlisted procedure, anterior segment of eye
- 67299 Unlisted procedure, posterior segment
- 67399 Unlisted procedure, ocular muscle
- 67599 Unlisted procedure, orbit
- 67999 Unlisted procedure, eyelids
- 68399 Unlisted procedure, conjunctiva
- 68899 Unlisted procedure, lacrimal system

REMOVAL OF IMPLANT vs REMOVAL OF FOREIGN BODY

Foreign body, in coding terms, is an object that has entered and is present in the body, but does not belong there and was not placed by the surgeon. This includes objects that are synthetic or natural in origin (wood, glass, metal etc).

In ophthalmology the list of sites includes:

- Corneal foreign bodies
- Intraocular foreign bodies (anterior and posterior segments)
- Foreign substances embedded in lacerations
- Conjunctival foreign bodies
- Orbital foreign bodies

Obviously, these objects arrive in the body part as a result of some type of trauma, such as an accident, natural force (wind blowing something in the eye) or other method of delivery.

An implant, on the other hand, is a manufactured object that has been placed by the surgeon as part of a surgical procedure. When there are complications related to the placement of the implant, its removal is often the procedure of choice.

Do not code the removal of an implant as removal of a foreign body.

In many instances there is not a code for removal of an implant – or its removal/revision may be included in the placement code. An example of this is CPT code 67218 (Destruction of localized lesion of retina…radiation by implantation of source [includes removal of source]).

Therefore, coding the removal of a previously placed implant often requires use of one of the unlisted codes.

Examples of specific ophthalmic codes that address **removal of implanted material** include:

- 65175 Removal of ocular implant
- 65920 Removal of implanted material, anterior segment of eye
- 67120 Removal of implanted material, posterior segment, extraocular

- 67121 Removal of implanted material, posterior segment, intraocular
- 67560 Orbital implant (implant outside muscle cone); removal or revision

Examples of specific ophthalmic codes that address **removal of foreign bodies** include:

- 65205 Removal of foreign body, external eye; conjunctival superficial
- 65210 Removal of foreign body, external eye; conjunctival embedded
- 65220 Removal of foreign body, external eye; corneal, without slit lamp
- 65222 Removal of foreign body, external eye; corneal, with slit lamp
- 65235 Removal of foreign body, intraocular; from anterior chamber of eye
- 65260 Removal of foreign body, intraocular; from posterior segment, magnetic extraction
- 65265 Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction
- 67413 Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of foreign body
- 67430 Orbitotomy with bone flap or window, lateral approach (Kronlein); with removal of foreign body
- 67938 Removal of embedded foreign body, eyelid

Examples of procedures that should **not** be coded as removal of foreign body include: removal of silicone tubes from the nasolacrimal system (do not use 30300 or 65830); removal of punctual plugs (do not use 68530); removal of orbital implants placed to correct orbital floor fractures; removal of enucleation/evisceration implants.

WOUNDS vs LACERATIONS vs PERFORATIONS vs DEHISCENCES

A **wound,** as defined by Merriam-Webster's dictionary, is an injury to the body consisting of a laceration or breaking of the skin or mucous membrane – usually by a hard or sharp object. It also has another definition of an opening made in the skin or a membrane of the body incidental to a surgical operation or procedure.

A **laceration** is a traumatically induced event that results in an external opening of skin and mucuous membrane, often described as a jagged wound. Ophthalmic laceration repair codes are found in both the Eye section and Integumentary section of CPT.

They include:

- CPT Repair codes 12011 – 12018; 12051 – 12057; 13150 – 13153
- CPT Adjacent Tissue Transfer or Rearrangement codes when applicable 14060 – 14061

- CPT 67930 and 67935 (partial thickness and full thickness suture of wound)

Examples of procedures that should not be coded as laceration repair: resuturing of incisional site after upper eyelid blepharoplasty; repair of broken frontalis sling.

A **dehiscence** is a bursting open or parting of the lips of a surgical wound. Generally, the area has been sutured previously.

Repair of a wound dehiscence should **not** be coded as a laceration repair. Use the following CPT codes when applicable or the unlisted code if necessary:

- 12020 Treatment of superficial wound dehiscence; simple closure
- 12021 Treatment of superficial wound dehiscence; with packing
- 13160 Secondary closure of surgical wound or dehiscence, extensive or complicated

A **perforation,** such as occurs with corneal ulcers, is caused by a disease process with penetration of a surface, and should **not** be coded as a laceration repair.

Example: The use of glue for repair of a perforating corneal ulcer. There is no CPT code for application of glue to the cornea to treat this condition. The CPT code 65286 for repair of a corneal laceration using glue is not correct and you should use the unlisted code.

ORBITOTOMY vs OSTEOTOMY

There are basically two sets of orbitotomy codes in the Eye and Ocular Adnexa section of CPT.

In CPT all of the code descriptor up to the semicolon pertains to the first code listed as well as the subsequent codes that are indented and the first word is not capitalized.

The first set of codes (67400, 6405, 67412, 67413 and 67414) have the following preface: “Orbitotomy without bone flap (frontal of transconjunctival approach);”.

The second set of codes (67420, 67430, 67440, 67445 and 67450) begin with “Orbitotomy with bone flap or window, lateral approach (eg, Kronlein);”. The definition of the surgery for this set of codes involves the use of an oscillating saw to remove bone as the surgical approach, **not as part of the procedure**. Removal of bone may also occur as part of the procedure if an osteotomy, decompression or other bone removal is performed; however, if a “window” of bone was not removed in order to perform the operation then this set of codes should not be used.

Just because bone was removed during the surgical procedure does not entitle the coding of the procedure as an orbitotomy with bone flap.

In summary, it behooves surgeons to understand CPT nomenclature when selecting codes in order to remain in compliance with Medicare regulations while optimizing reimbursement.

Published in Ocular Surgery News September 10, 2010 and October 10, 2010 in two parts.