Chapter 4
How Do I Get Paid: Medicare, Medicaid, Insurance, Billing Pearls

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Introduction

However you are paid and whatever type of practice you join, you need to know how to bill to justify your salary. Whether you are in a large hospital-owned practice where reimbursement is based on RVUs or in private practice and paid out of accounts receivable, maximizing billing improves reimbursement and eventually your take-home pay. Many surgeons think billing is too complicated for them to bother learning and would rather send operative notes to their coders and hope for the best. But there are many good reasons why every surgeon needs to understand billing.

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D.B. Renton et al. (eds.), *The SAGES Manual Transitioning to Practice*, DOI 10.1007/978-3-319-51397-3_4

You will always miss opportunities to be paid if you do not understand the rules. Imagine a professional football coach that did not know the ever changing NFL rules, and how difficult it would be for that coach to win. Taking this a step further, millions of fantasy football fans watch and know every rule of the NFL despite yearly changes. Surely, every surgeon is as capable as any of these fans; it is simply a matter of motivation. Understanding which words or descriptions identify an operation as more complicated, and therefore more highly reimbursed, will allow the surgeon to use these descriptions upfront. Knowing that there is a more appropriate code will allow for better compensation. You only need to know how to document to justify the code for which you are expecting to be paid.

Several decades ago, the most important part of billing was based on procedures done in the operating room. But reimbursement for operations has shrunk and patient management encounters have become more highly valued. Now, billing for each of the components of care has become more important. The relative value of a complex oncologic resection will always be higher than that of an office visit, but billing for all periods of care regardless of their relative worth can increase production by 20–40% and increase take-home pay by even more. Think of it as filling your basket with eggs. Some of those eggs may be worth a lot more than others, but if you spend your effort on only the high value eggs, you will miss the abundance of lower value ones. At the end of the day, you need to fill your basket and the value of each egg matters less than picking up every one available.

The following paragraphs will define and provide examples of various terms used in billing and coding. Sample surigcal scenarios with their appropriate CPT codes are used to illustrate the process. Do not get hung up on memorizing CPT codes, modifiers, etc. and focus instead on broader concepts.

RVUs, Billings and Collections

Any service performed can generate a bill to the patient or his or her insurance company. You send the bill with a description of the procedure (see CPT below), associated diagnosis (see ICD-10 below), and a charge. What you get paid though is almost never the entire charge. Historically charges were based on the highest amount that was likely to be paid and often have not changed or have increased within the last several years. However, the amount actually collected has gone down markedly. Billings measures the total amount billed while collections indicates the amount that is actually paid. When you sign a contract with an insurance company, you or your practice agrees to accept their fee schedule and generally be paid less than you are billing. Also, in some situations you may bill a patient but never be paid, particularly with uninsured patients. Billings are always higher than collections, and collections are based on payer mix. Payer mix refers to the relative percentage of privately insured, Medicare, Medicaid, and self-pay (uninsured) patients. Generally private insurances pay the most while self-pay patients pay the least. Medicare and Medicaid typically fall somewhere in between in terms of collections. Relative Value Units (RVUs) are nonmonetary measure of the value of a procedure or service. RVUs are useful as they do not vary with payer mix and represent a work value. They also allow comparison across specialties. Generally, the higher the RVU value the greater the reimbursement, but this is not a linear arrangement. Patient care services should not be disparaged as a billing source. If done correctly, these can earn as much as procedural billings. Average RVU production varies a great deal amongst different specialties, and specialties that generate higher RVU values are generally paid more. Specialties with higher salaries typically are paid a higher average dollar amount per RVU. Physicians are never paid solely by the number of hours worked.

CPT Codes

CPT is a five-digit code that represents a billable act of care. The complexity and difficulty of a procedure determines the appropriate CPT, which determines allowable charges and associated RVUs. CPT codes are not specialty specific, and the same procedure done by two different specialists is reimbursed the same amount. Most operative procedures have specific codes but for new or rare procedures an unlisted code can be used. Generally, it is better to pick the most appropriate code and use unlisted codes sparingly as unlisted codes reimburse inconsistently. Unlisted codes require a greater amount of documentation, do not reimburse as quickly and require a higher amount of administrative overhead to deal with denials or requests for more information. Moreover, most RVU-based reimbursement systems fail to recognize the work of procedures documented with unlisted codes as the unlisted code has no RVU valuation in the Centers for Medicare and Medicaid Services (CMS) database. However, for newer procedures, unlisted codes may be the only viable option to gain reimbursement.

There are codes for both Evaluation and Management (E&M) and procedures. Examples of E&M codes are those for office encounters, inpatient consults, and ED admissions. Further there are modifiers for these CPT codes that can do several things, including allowing you to bill multiple codes on the same day or within the global period. Some modifier codes allow for billing on the same day as the initial evaluation. CPT codes are grouped by procedure type with the following classes: 1xxxx for skin and soft tissue codes; 2xxxxx for orthopedics; 3xxxx for vascular codes; 4xxxx for gastrointestinal; 5xxxx for urology, gynecology, and endocrine; 6xxxxx for neurosurgery and ophthalmology; 7xxxx for radiologic interpretation; 8xxxxx for pathology and lab procedures; and 9xxxx for E&M. A general surgeon may use codes from all of the above categories, but skin, gastrointestinal, vascular, and E&M are the most frequently used. CPT codes must be linked to an ICD-10 code that represents the diagnosis for which the procedure or evaluation is performed.

Global Period

The care of patients after a procedure includes all appropriate postoperative treatments and is termed the global period. The length of the global period varies depending on the procedure performed. Endoscopy procedures have no global period. Minor procedures, such as removal of skin lesions, drainage of an abscess, mass removal, and other procedures that can generally be done in the office, have a 10 day global period. The location at which a procedure is performed does not change the global period. Resection of a skin cancer in the operating room has the same 10 day global period as a resection done in the office. Major procedures, generally those that are done in operating room, have a 90 day global period. The global period includes the 24 h prior to the procedure as well. For example, endoscopy procedures are considered zero day global codes, meaning that 24 h prior to the procedure and all events on the day of the procedure are included in the global period. Care unrelated to the primary problem is not included in the global period but documentation must make it clear that a seperate issue is being assessed and treated. Evaluation and Management (E&M) procedures done in the global period require an appropriate modifier. Also evaluation or treatment that is not part of the usual postoperative care is billable. This could include critical care delivered in the postoperative period or the treatment of complications not directly related to the procedure. This is where discussions with your coders become very helpful.

Modifiers

Modifiers are two-digit codes added to CPTs to clarify coding and often allow multiple codes to be billed on the same day of service or allow payments for CPTs billed within the global period. Common modifiers used in general surgery include the following:

Bilateral-50: Bilateral inguinal hernias are repaired. Bill 49505 and 49505-50. The first procedure is paid in full and the second at a reduced rate, usually 50%.

Decision for surgery-24 (office) or -57 (inpatient): This explains that you evaluated the patient and made a clinical decision to operate. Example: You see and evaluate a patient with right lower quadrant pain and decide to operate on them for appendicitis. The codes billed are 99222-57 and 47590. The E&M code otherwise is not paid on the day of surgery. You are not allowed to bill an E&M code on the day of an elective surgery when you update the history and physical.

Separate procedures-59: You perform two separate CPT codes on the same patient on the same day, generally this requires separate incisions. Example: You place a port-a-cath the same day as a laparoscopic right colectomy. As they are generally not done together or through same incision, you bill 44205 (lap right colectomy, primary procedure), and 36561-59 (port-a-cath insertion). The first procedure is paid in full and subsequent procedures are paid at a reduced rate that is state dependent. The better paying procedure should be billed without the modifier.

Return to OR staged (planned)-58: This covers procedures done within the global period after the initial operation when the subsequent operation is clearly planned. Example: You do an open breast biopsy that returns cancer, you return to OR in 7 days (within the global period) for a simple mastectomy. The appropriate codes are 19120 (open breast biopsy) on the day of the initial surgery and 19303-58 (simple mastectomy) on the day of the second surgery. This also covers if a subsequent procedure is significantly more involved than the initial surgery. Both procedures are paid in full.

Return to the OR for a related issue-78: This covers procedures in the global period not planned but requiring a return to the operation room clearly related to the primary procedure. Example: You evacuate a hematoma the day after an open inguinal hernia repair. 49505 (open inguinal hernia) is billed for the initial date of surgery and 10140-78 is billed for the return the next day. The second procedure is paid at a reduced rate, usually 50%.

Return to OR for unrelated issues-79: This covers procedures in the global period not planned but requiring a return to the operating room that is clearly not related to the primary procedure. Example: You electively repair a right inguinal hernia via a laparoscopic approach. The patient then returns 40 days later with peritonitis from a perforated ulcer. The original surgery is billed as 49650, lap inguinal hernia, and the subsequent surgery is billed as 44840-79 (Gastrorrhaphy, suture of perforation). Both are paid in full.

First assistant—FA: A qualified resident or fellow assistant is not available needs to be documented in note. A first assistant bills the same code as the primary surgeon with FA modifier to indicate he or she was serving as first assistant. This pays between 10–20% of primary procedure.

For a list of frequently used modifiers, see Appendix.

More Considerations for Major Operations

Major operations are billed on the most complex portion rather than each of the parts. An exploratory laparotomy for lysis of adhesions with bowel resection is billed only as a small bowel resection. Billing for each of these parts is considered unbundling. To maximize the efficiency of your billing, use the appropriate code for the most complex part of the operation. Avoid unspecified codes unless no other codes apply. Procedures occurring subsequently in the global period need appropriate modifiers and the choice of an appropriate modifier is reflected in the amount paid. A return to the operating room is paid at about 50% when it occurs in the global period unless the return is planned at the time of the original operation or is more extensive (in which case a modifier 58 is required). A laparoscopic procedure that is converted to open is billed as an open procedure.

Multiple procedures will pay 100% for the first code and less on each subsequent procedure. The percentage paid on each subsequent procedure varies from state to state. For procedures performed at the same visit by two or more different surgeons, each surgeon bills for his or her procedure indepen-

dent of the other. For example, a right oophorectomy performed by a gynecologist at the same time as a lap appendectomy would each be paid in full. Procedures performed by the same surgeon via different incisions will often pay at half their value (for example, simultaneous right and left inguinal hernia repairs or a PEG at the same time as a port-a-cath placement). Add-on codes are special in that they pay in full in addition to the primary code, i.e., mobilization of the splenic flexure is an add-on code for left colon procedures. Placement of a feeding jejunostomy is another add-on code. Several of the procedures done by length or size have add-on codes to increase size. For example, in complex closure of 14 cm axillary wound, appropriate billing includes CPT 13132 (complex closure axillary wound 2.5–7.5 cm) and CPT 13133 billed twice (complex closure axillary wound additional length up to 5.0 cm).

For multiple endoscopic procedures, reimbursement is typically 50% for a procedure with a separate approach. Thus EGD would be paid at 50% if performed at the same time as a colonoscopy. Reimbursement for multiple endoscopic procedures with the same approach is more complex. For example, tattooing a lesion (CPT 45381) and snare polypectomy (CPT 45385) are paid as the stem procedure (diagnostic colonoscopy, CPT 45378) plus the difference between the stem and each of the other procedures (45385-45378 + 45381-45378). This amounts to a modest increase in what is reimbursed.

Hernia Billing

Hernia billing includes some special considerations regarding the differences between inguinal and ventral, laparoscopic and open, use of mesh in repair, patient's age, and status of hernia. First we will consider open hernia repairs. Open inguinal hernia CPTs always include mesh, if used, and are divided into reducible, incarcerated or non-reducible, and strangulated. They are further stratified by initial or recurrent with a separate category for sliding hernias. Finally inguinal hernia repairs in patients under 6 month of age, 6 months to 5 years old, and over 5 years old each have different CPT codes.

Open umbilical and epigastric hernia repairs have separate CPT codes that always include mesh and are separated only into reducible and nonreducible. Open incisional and ventral hernias are considered the same, but they are divided into initial or recurrent and reducible or nonreducible. Use of mesh is a separate add-on code (49568) for ventral and incisional hernia repair. Further, open repair using a retrorectus mesh and separation of components (TARS repair, for example) can be billed as the separation of components, (15734, myocutaneous flap, trunk) in addition to the hernia repair codes. Commonly both sides are mobilized so a bilateral muscle flap code is utilized. For example, a large reducible, incisional hernia repaired with bilateral transversus abdominis release and mesh placed in retrorectus space can be billed as 49560 (initial repair ventral or incisional hernia, reducible), 15734-59 (code and modifier for a myocutaneous flap) and 15734-50-59 (code and modifiers indicating a bilateral myocutaneous flap) and 49568 (add-on code for TAR). Finally, there is separate code for open repair of a Spigelian hernia.

Laparoscopic codes all include mesh, so an add-on code for mesh is not appropriate in these cases. Laparoscopic inguinal hernias are separated into initial and recurrent hernias. Laparoscopic umbilical, epigastric, Spigelian, and ventral hernias are all grouped together under two codes splitting reducible hernias from nonreducible. Laparoscopic repair of incisional hernias is divided into initial and recurrent repairs and again by reducibility.

Outpatient E&M Codes and Associated Minor Office-Based Procedures

There are separate codes for the initial evaluation and subsequent office visits for outpatients and for initial evaluation and subsequent daily charges for inpatients. Initial evaluations for clinic visits are subdivided into initial management codes (9920x) and consult codes (9924x). Consults pay better than equal level initial management codes but require

specific documentation. The exact language used by both the requesting physician and the consulting physician is important. There has to be a request from another physician that uses the specific language of consultation or evaluation regarding a specific clinical problem or symptom. "Refer to Dr. Smith for gallstones" is not considered appropriate language of request to justify a consultation. The consult note must include the verbiage "Patient seen in consult at the request of Dr. Smith for x," and a copy of the consult note must be sent back to the physician requesting the consult. Neither Medicare nor Medicaid recognizes consult codes. Subsequent visits are billed using established patient codes (9921x). A patient who has not been seen in three years becomes a new patient from a billing standpoint.

Consult codes for a new problem can be applied to new or established patients. The codes are based on complexity and require documentation to justify each level. Documentation requirements break down into a minimum number of elements from HPI, ROS, exam, and past medical/family/social history elements. The elements of chief complaint include location, quality, severity, duration, timing, context, and modifying factors, and the number of elements required varies based on the level of billing (see Table 4.1).

For each of these different levels, there is a degree of complexity than should be documented. There is also a time requirement for each of these levels (Table 4.2). For surgeons, this is often the most straightforward means to document this

Table 4.1 New outpatient evaluations and outpatient consultations. Requirements for each element type based on level of billing

CPT code	HPI	ROS	Exam[a]	PMFSH
99201/99241	1	0	1	0
99202/99242	1	1	2	0
99203/99243	4	2	2	1
99204/99244	4	10	8	3
99205/99245	4	10	8	3

[a]For physical exam documentation, each arm counts as a separate area. Skin is also one area

TABLE 4.2 Office initial visit and consult: time requirement based on level and visit type

CPT code	Time requirement (in minutes) Initial visit	Consult
99201/99241	10	15
99202/99242	20	30
99203/99243	30	40
99204/99244	45	60
99205/99245	60	80

level of complexity of care. Time spent in counseling/coordinating care, if at least 50% of the encounter length, can be used to justify the level complexity element. This means if you spend 30 min discussing how an operation is done and the risks/benefits, then you have justified the complexity for a level 4 consult or a level 5 new patient encounter. Consult codes always have a somewhat longer time requirement than initial visit codes, and often the next level of new patient encounter is nearly equivalent to the lower level consult code.

Office-based procedures can be billed separately with a modifier 24 added to an E&M code. Common procedures include punch biopsy, removal of skin tumors (benign or malignant), mass removal, anoscopy, and abscess drainage. Two of these are more complex: the removal of skin lesions and subcutaneous mass removal.

Skin lesion excision is divided by benign and malignant lesions, the size of the lesion, and the area of the body. The size component is based on the width of the lesion including margins. The length of the incision does not matter. If the wound is closed in two layers, an intermediate wound closure code can be added which depends on the length of the wound and the area of the body.

For removal of masses below the skin, including lipomas and sebaceous cysts, billing is dependent on body area, mass size, and mass depth (subcutaneous versus below the fascia). These excisions are represented by 2xxxx codes, with there being four codes for each body area.

Inpatient E&M Codes and Procedures

Admission CPTs are divided into only 3 codes, 99231–99233, and, similar to outpatient visits, have associated HPI/ROS/EXAM/PMFSH and time requirements that can be used to justify complexity. Level 1 admissions have fewer elements than level 2 or 3, which have the same required number of elements but differ in the time requirement (see Table 4.3).

Consult codes are broken into five levels with similar element and time requirements to the admission codes, as outlined in Table 4.4.

Subsequent visits are billed per day if the patient does not receive an operation. These can generate significant revenue particularly on trauma, critical care, and emergency general surgery services. Follow-up visits on consults and admissions are billed the same, and like the previously discussed codes, are based on complexity but also have required elements (see Table 4.5). Level 1 (99231) indicates an improving problem.

Table 4.3 Admission E&M: Element and time requirements for admission CPTs based on billing level

CPT code	HPI	ROS	EXAM	PMFSH	Time
99231	4	2	2	1	30 min
99232	4	10	8	3	50 min
99233	4	10	8	3	70 min

Table 4.4 Hospital inpatient consultation: Element and time requirements for inpatient consults based on billing level

CPT code	HPI	ROS	EXAM	PMFSH	Time
99251	1	0	1	0	20 min
99252	1	2	1	0	40 min
99253	4	2	2	1	55 min
99254	4	10	8	3	80 min
99255	4	10	8	3	110 min

TABLE 4.5 Inpatient follow-up

CPT code	HPI	Exam	ROS	Time
99231	1	1	0	15 min
99232	1	2	1	25 min
99233	4	2	2	35 min

Level 2 (99232) is used for a stable but not resolving issue, and level 3 (99233) demonstrates significant deterioration of the patient's condition. Hospital discharges can also be billed. Code 99238 is appropriate for discharges taking less than 30 min while 99239 are used for discharges taking longer than 30 min.

Differences with Medicare and Medicaid

There is generally little difference for Medicare and Medicaid in terms of coding except for a few instances for surgeons. Medicare and Medicaid no longer recognize consultation codes and all inpatient and outpatient encounters are billed using new patient or established patient codes on the outpatient side, and patient admission and follow-up codes on the inpatient side. Medicare and Medicaid use a special code for screening colonoscopies, G0121 for normal risk patients, and G0105 for high-risk patients instead of more typical 45378 used by private insurance companies. This last item is not often fixed by coders and is not something most surgeons need to know. Medicare is different from other insurances in that it offers the option of being a participating provider and agreeing to their fee schedule that is 5% higher than that for a nonparticipating provider. Nonparticipating providers can charge a higher overall fee however. Medicare as the insuring agent pays less to a nonparticipating provider and the higher overall fee is generated by billing the balance to the patient. Medicare still limits the overall charge to 115% of their fee schedule. The choice to not participate exists only in the private practice model, though in theory larger organizations could decide not to participate.

ICD-10

Diagnoses are specified by ICD-10 codes. ICD codes stand for International Statistical Classification of Diseases and Related Health Problems. ICD-10 refers to the newest iteration (10th Edition) that went into effect in the United States in October of 2015. It had been around for 10 years prior to its adoption. It effectively changed the base 13,000 codes in ICD-9 to 68,000 codes in ICD-10. ICD-9 was over 25 years old and medicine has changed significantly. ICD-10 allows for more specificity in coding. For those not familiar with ICD-9, this probably has not been much of an issue. However, this new coding system completely changed all codes, so those who were familiar with common codes are now left searching for their new counterparts. ICD-10 requires information about laterality, if an encounter is initial or subsequent, and more details of the condition. Electronic medical records make this transition much easier.

Starting Practice

Starting to practice in a new location requires several steps to allow you to be paid. The initial step is obtaining licensure from the state medical board and the DEA. You also need to obtain an NPI number (National Provider Identifier) which is a unique ten-digit number and is used by both Medicare/Medicaid as well as private insurance. Both state and DEA licenses can take several months to obtain, and certain states, Florida and Texas for example, take even longer and have significantly stricter licensure requirements. Only after you have both of these licenses can you apply for privileges at the hospitals at which you will be admitting, seeing consults and operating. This also can take several months to process as they go back to at least medical school and obtain records. Every place you work subsequently increases the length of the process. Also, as a provider you will need to sign contracts with each of the insurance companies prior to seeing any

patient covered by them. So the entire process from signing a new contract to actually being able to see patients and bill for your services is at least 3 months and often 6 months. Sometimes services can be billed retroactively or under your partner's name.

Test your Knowledge

1. An elderly patient is seen in the emergency room with free air in the abdomen, sepsis, and multiple medical comorbidities. You evaluate the patient, review the labs and CT images, and discuss operative plans and options with patient and his family. You document in your admission H&P 4 elements of history, 10 ROS, 8 exam, and 3 PMFSH and that you spent 35 min discussing with the patient and his family and coordinating care. You go to operating room and perform exploratory laparotomy, resection of the sigmoid colon, and creation of an end colostomy. You mobilize the splenic flexure to allow the colostomy to reach an ideal site and place a feeding jejunostomy. What are the appropriate codes/level of billing?
2. True or False: A plastic surgeon who does a local flap procedure will get paid more than a general surgeon doing same procedure?
3. True or False: I remove the gallbladder of a patient, and a gynecologist comes in at end of the procedure and removes an ovary. I should bill just for the cholecystectomy and will get paid the same amount as it were done as an isolated procedure.
4. True or False: I can bill for an H&P on the day of surgery for a patient I originally saw in the office and scheduled for an elective procedure.
5. True or False: I can bill for an admission from the ER and an operation on the same day for a patient seen for the first time that day.
6. You see a patient in the office with a prior punch biopsy showing squamous cell cancer on two areas: the left upper arm and

the right thigh. You evaluate the patient, perform a basic history and exam, and recommend removal of both skin cancers at that same visit. The left arm lesion is 3 cm long and 1.7 cm wide on the upper arm. The right thigh lesion is 5 mm and round. You remove the left arm lesion with an elliptical incision 8 cm long by 2.8 cm wide and repair this in two layers, and excise the right thigh lesion via a 4 cm by 1.3 cm ellipse which is also repaired in two layers. What do you bill?

Test your Knowledge

1. 99223-57 (level 3 admission with a decision to operate modifier), 44143 Colectomy with end colostomy (primary procedure), 44139 Mobilize Splenic Flexure (add-on code), 44015 Tube or Needle Jejunostomy (second add-on code)
2. False, CPT is independent of specialty.
3. True, and note no modifier is required. There is a two surgeons modifier if two surgeons are required to complete a procedure, but as each surgeon in this example has a separate CPT and separate diagnosis, each is billed as they are independent events.
4. False, the decision to operate was made already in the office. Even if you produce a new History and Physical, this is part of operation billing that day.
5. True. Like number one, you needed to evaluate and decide if an operation was appropriate.
6. 99201-24 (level 1 new patient with decision to operate), 11063 (excise malignant skin lesion of trunk, arm, or leg, 2.1–3.0 cm), 11062-57 (excise malignant skin lesion of trunk, arm, or leg, 1.1–2.0 cm with separate procedure modifier), 12034-57 (intermediate repair of incision 7.6–12.5 cm of arm, leg, scalp, or trunk). Note each lesion removed is listed separately even though they are in the same "body area," but an intermediate repair is the sum of all repairs for a given body area, with body area defined by ICD-10. If you had removed a lesion from the patient's face instead of the right thigh, then a separate code for intermediate repair of the face would be appropriate.

Final Tips

Billing between the anesthesia and the surgeon need to match, otherwise the second bill to arrive will not initially be paid. Some surgeons tell the anesthesiologist the codes at end of procedure, which often they appreciate.

Working with your coder is an invaluable learning experience and can increase understanding for both the surgeon and the coder. The coder is one of the most important of your employees. They require ongoing education as rules for coding change constantly.

The last example showed 4–5 codes that could be used for two skin cancers. It is less important that you know that each can be billed for independently and the exact CPTs used. It is more important that you document the width, including margins, of each lesion, whether it is benign or malignant, and the location from which it was excised. A coder can then fill in the details. In similar fashion, it is less important to know the skin closure codes than to know what constitutes a simple, intermediate, or complex closure and the need to document the total length.

There is no way you will remember all of these CPT codes. Having a CPT manual written by the AMA in the operating room and office is very helpful. A good substitute is a coding app for your smartphone called **ABEO coder** that is available for free. This app was designed for anesthesiologists but is very useful tool. Descriptions are more limited than those in the AMA manual but still very useful, and it allows you to save your favorite codes.

Further references include basic and advanced coding workshops, website and hotline, all sponsored by the American College of Surgeons.

Coding courses: https://www.facs.org/advocacy/practmanagement/workshops

Coding bulletins and hotline: https://www.facs.org/advocacy/practmanagement/cpt

Appendix

Frequently used modifiers for surgical billing

Code	Use	Example
-24	For evaluation and management of a problem unrelated to the primary diagnosis completed within the global period	A patient who has previously undergone a hernia repair returns within the global period with complaint of biliary colic
-25	For evaluation and management of a problem unrelated to the reason for a procedure completed on the same day as the procedure	A patient presents for removal of a skin lesion with a new onset right groin pain
-50	To indicate bilaterality	A right inguinal hernia repair completed on the same day as a left hernia repair (only one CPT will carry this modifier)
-53	To indicate the procedure was aborted prior to completion	A patient develops an allergic reaction to local anesthetic requiring the planned hernia repair be aborted. An operative note must be submitted indicating why the procedure was aborted and at what step.
-57	For evaluation and management of the primary problem if originally diagnosed on the same day as a procedure	The workup of a patient in the Emergency Department who later goes to the OR for an appendectomy

-58	For a planned take back or staged procedure when this procedure is completed within the global period	A mastectomy that takes place within the global period of previously completed open breast biopsy
-59	To indicate a separate and unrelated procedure that was completed on the same day as the primary procedure	A port-a-cath placement completed at the same time as PEG placement
-78	To indicate an unplanned return to the OR related to the primary procedure	A patient develops fascial dehiscence after a laparotomy requiring return to the OR for exploration and fascial closure
-79	For an unplanned return to the OR unrelated to the original procedure	A patient who underwent inguinal hernia repair develops appendicitis within the global period