Coding for Gastrointestinal Endoscopy

Audio Seminar/ Webinar

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Practical Tools for Seminar Learning
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Margi Brown, RHIA, CCS, CCS-P, CPC

Margi has over twenty years of experience in Health Information Management (HIM) field covering hospital outpatient, inpatient, surgical centers, physician office, clinic, law firms, consulting, and third-party carrier areas. Ms. Brown earned her Bachelor of Science degree in Health Information Management from the University of Central Florida. Areas of expertise include coding, education, audits, compliance, ensuring optimal reimbursement, operational assessments, billing office process flows, reviewing tools, revising forms, implementation of policies and procedures and assisting in making the process more efficient and “doable”. Margi has extensive hands-on experience working with physicians in the hospital setting and in the office/clinic environment. She brings the hospital outpatient and physician component together.

A knowledgeable and versatile speaker, Ms. Brown had done numerous presentations for a wide-ranging audience including national and state associations such as the American Health Information Management Association-AHIMA, Florida Health Information Association-FHIMA, Tennessee Health Information Management Association-THIMA as well as serving as a guest speaker for several groups. Ms. Brown was a consultant and seminar instructor through the Southern Medical Association (SMA) and presented basic, advanced and specialty-coding classes for physicians, instructed a medical billing course for the University of South Alabama, and was the Eastern Division Coding Consultant for the Medical Group Management Association-MGMA in 2000. She instructs on how accurate coding and complete documentation connects to optimal reimbursement, following guidelines and meeting compliance regulations in real world settings.

Prior to joining DCBA, Margi has been a consultant working with a variety of facilities. She has worked with APC implementation, assessment, CDM revision, auditing, and education in the hospital arena. Additionally, she has worked with coding, medical necessity, denial management, compliance, and documentation improvement for both the hospital and the physician areas. She has held previous positions in the physician world such as Director of areas of Coding and Compliance for Phycor in Nashville, TN; Coding, Compliance, and Reimbursement for the Infirmary Health System in Mobile, AL; and Matthews Clinic in Orlando, FL. Previous hospital positions include Manager of Prospective Payment, Assistant Director of Health Information Management, DRG coordinator, and Supervisor in a large size level 1 trauma teaching facility over coding, as well as other areas.

Robert S. Gold, MD

Dr. Gold is known nationally for his educational presentations regarding the clinical orientation of coding in AHIMA audio conferences and at the 2002 National Conference for the Society for Clinical Coding. His contributions of Clinically Speaking articles in Briefings on Coding Compliance Strategies have been valuable to coding professionals and his A Minute for the Medical Staff articles in Medical Record Briefings have demonstrated value to the documentation practices of medical staff members.

Dr. Gold is a co-founder of DCBA, Inc, a consulting company that evaluates physician documentation to support the compliant assignment of ICD-9-CM and CPT-4 codes. They specialize in physician led education of HIM personnel, physicians and Documentation Specialists on the clinical aspects of diseases and procedures and how accurate and specific codes support professional and financial profiling for the hospital and for the medical staff.
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**Objectives**

- At the end of this session you *should*
  - Improve your coding knowledge with a review of the most current ICD-9-CM and CPT coding guidelines related to GI endoscopy.
  - Understand coding and modifier usage for screening endoscopy, multiple endoscopy, snare vs. ablation vs. biopsy procedures....

**GI Topics of Discussions**

- The gastrointestinal tract anatomy
- Everything you wanted to know about endoscopes and tools
- Diagnostic considerations of endoscopy
- Procedural considerations of endoscopy
The GI Tract
Pertinent thought processes for coding

- Review embryologic development
- Review anatomy of the gastro-intestinal tract and its circulation
- Disease of the organs
  - Esophagus
  - Stomach
  - Duodenum
  - Small intestine
  - Large intestine
  - Liver
  - Pancreas

Disease of the vessels
  - AVM (angiodysplasia)
  - Aneurysm
  - Varices

Gastrointestinal bleeding and sequencing

Endoscopic Procedures

Rules and regs regarding coding and sequencing
Embryology of the GI Tract

- Straight tube
  - Foregut
  - Midgut
  - Hindgut
- Open to yolk sac
- Herniates into umbilical cord
- Returns to abdomen
- 270° rotation based on superior mesenteric artery
- Fastens to back

Anatomy of the GI Tract

- Esophagus
- E-G junction
- Stomach
- Duodenum
- Jejunum/Ileum
- Colon
  - Right/appendix
  - Transverse
  - Left
  - Sigmoid
- Rectum
- Anus
Abdominal Quadrants

Liver & gallbladder
- Pylorus
- Duodenum
- Head of pancreas

Right adrenal gland
- Portion of the Right kidney
- Hepatic flexure of the colon
- Portion of ascending & transverse colon
LUQ

- Left lobe of liver
- Spleen
- Stomach
- Body of pancreas
- Left adrenal gland
- Portion of the Left kidney
- Splenic flexure of colon
- Portions of transverse & descending colon

RLQ

- Lower pole of the right kidney
- Cecum & appendix
- Portion of ascending colon
- Bladder (if distended)
- Ovary & salpinx
- Uterus
- Right spermatic cord
- Right ureter
**LLQ**

- Lower pole of the left kidney
- Sigmoid colon
- Portion of descending colon
- Bladder (if distended)
- Ovary & salpinx
- Uterus (if enlarged)
- Left spermatic cord
- Left ureter

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**Why Scope?**

**Diagnosis**
- Abdominal pain
  - Inflammation
  - Vascular insufficiency
  - Obstruction
- Gastrointestinal bleed
  - GI origin or not
  - What’s the pathology
- Prophylactic
  - Familial disease

**Treatment**
- Stop the bleed
- Provide alternative access to GI tract
- Not much else

**Screening**
- History of ...
- High risk for ...
- Follow-up
Abdominal Pain

- Inflammation
  - Esophagitis, gastritis, colitis, diverticulitis, cholecystitis, pancreatitis, other “it is”-es
  - Ulceration - due to peptic disease, ingestion (ASA, lye, etc.), Barrett’s, ulcer of rectum, ulcerative colitis, Crohn’s (ulcerative esoph - NO!)

- Vascular
  - “Ischemic colitis”
  - Acute mesenteric occlusion (dead bowel)
  - Intestinal angina

- Obstruction
  - Tumor, internal hernia, volvulus (stomach or colon), intussusception

Gastrointestinal Bleed

- Inflammatory causes (diverticulitis, ingestions, Crohn’s)
- Infective causes (H. pylori diseases)
- Neoplastic causes (benign, malignant)
- Congenital causes (congenital polyps)
- Traumatic causes (Mallory-Weiss, tears and rents)
- Vascular causes (AVMs, varices, acute mesenteric vascular ischemia, chronic vascular insufficiency)
Prophylactic vs. Screening - almost the same

- Patients with familial polyposis WILL get polyps - need surgery in time
- Patients with individual polyps MAY get more polyps
- Patients with cancers MAY get other cancers or recurrences of original
- Patients after variceal bleed and procedures on varices MAY get repeat

How to Get Into the GI Tract

Where?
- Through the mouth
- Through the anus
- Through a stoma

How?
- Rigid scope (esophagoscope, sigmoidoscope, anoscope)
- Flexible fiber optic scopes
Vascular Supply to GI Tract

- Celiac axis to stomach, spleen, pancreas and liver
- Superior mesenteric artery to tail of pancreas, duodenum to midtransverse colon
- Inferior mesenteric artery to left colon and upper rectum
- Internal iliacs to lower rectum

Veins of the GI Tract

- Inferior mesenteric joins splenic vein
- These join superior mesenteric vein
- Left gastric vein and its branches join portal vein
- Brings food into liver
- Portal system
**Portosystemic Shunts**

**Natural internal decompression for patients with cirrhosis**
- Cardia of stomach with esophageal veins
- Umbilicus with falciform ligament (caput medusae)
- Hemorrhoidal veins

**GI Bleeding Issues**
- Hemoptysis
- Hematemesis
- Melena (melenic, not melanotic)
- Hematochezia
- Heme Positive stool

WHERE’S IT COMING FROM?
What Can Cause Guaiac +

- Bleeding gums
- Nose bleed
- Drinking blood (Munchausen's)
  - Easter pudding
- Pepto-Bismol®
- Gastrointestinal ulcerations or tumors or vascular problems (AVM, diverticulitis, varices)
- Spontaneous tear (Mallory-Weiss)
- Aortoduodenal fistula

GI Bleeding Issues

Bright red blood from above is NOT from lower bowel. It is from nose or mouth or esophagus, stomach or duodenum.

Bright red blood from below is NOT from upper intestinal tract.

Black blood from below must be from stomach (some duodenum, some esophagus)

Heme positive stool can be from anywhere!
GI Bleeding Terminology

- Spitting up of blood
- Hematemesis
- Hemoptysis?
- Melena
- “Black stool”
- Hematochezia
- “Maroon stool”
- “Bright red blood per rectum”

Vascular Malformations?
Vascular Malformations?

- CC 3Q 1996 states that arteriovenous malformations (AVM, vascular ectasia) and angiodysplasias of the intestine are the same thing and coded as:
  - 569.84 angiodysplasia intestine
  - 569.85 angiodysplasia intestine with hemorrhage
  - 537.82 angiodysplasia stomach or duodenum
  - 537.83 angiodysplasia stomach or duodenum with hemorrhage

Vascular Insufficiency 557.x

- Mesenteric vascular ischemia
- Intestinal angina
- Mesenteric infarction
- Mesenteric venous thrombosis
Endoscopy

Types of GI Scopes

- Rigid anoscope (operating)
- Rigid procto-(sigmoido)-scope
- Rigid esophagoscope
- Flexible fiber optic gastroscope
- Flexible fiber optic procto-(sigmoido)-scope
- Flexible fiber optic colonoscope
**Reasons to Scope**

- Red blood in stool that is presumably not from hemorrhoids (hematochezia)
- Hemoccult positive stools
- Melena?
- Risk factors for colon cancer
  - Follow-up from previous colon ca
  - Family history of colon ca
  - Familial polyposis/ulcerative colitis
- Large bowel obstruction
- Diagnosis of diverticular disease

**Coding Endoscopic Procedures**

- What was performed? Was it documented clearly?
- Diagnostic vs. surgical endoscopy?
- What was removed? Polyp, lesion, tumor, foreign body, other???
- What was the removal technique?
  - Watch the wording
  - Bipolar cautery, heat probe, hot snare, snare, cold biopsy...
- Check notes in the chapter, conscious sedation symbol ☺, radiology S&I
- When choosing the diagnosis, be sure to review the Path & Lab report
Esophagoscopy

- Limited to the esophagus
- Code range = 43200-43232
- Note the different methods/codes for injection, biopsy, excision, dilation, and ultrasound examinations.

Dilation of the Esophagus

- Code selection for dilation (expansion) of the esophagus depends on whether the procedure was a direct or indirect visualization and, if indirect, the dilation technique used.
  - For direct visualization with a scope, the correct code is 43220; an additional code, 43226, is also reported if a wire is inserted to guide the dilation.
  - For indirect visualization, the method of dilation (i.e. unguided sound, bougie, guide wire, string, balloon, Starck or retrograde (moving backward)) must be known to determine the correct code from 43450 to 43456 range.
    - 43450 = The scope was removed and Maloney dilator #54 .... was passed with ease. (Dilation performed 54FR savory dilator) See Coder's Desk Reference
    - Bougie = “A slender, flexible instrument for exploring and dilating tubal organs
**Esophagoscopy**

Esophagoscopy with:

- **Dilation of the esophagus methods**
  - **Endoscopic**
    - 43220 (balloon)
    - 43226 (guide wire)
  - **Manipulation (non-endoscopic)**
    - Bougie, guide wire, balloon, or dilator
    - 43450 – 43460

- **Injection**
  - 43201 (submucosal) injection, any substance
  - 43204 (sclerosis of varices) injection

**Esophagoscopy**

Esophagoscopy with:

- **Biopsy**
  - 43202, with biopsy, single or multiple
  - 43232 transendoscopic US-guided intramural/transmural fine needle aspiration/biopsy(s)

- **Removal of tumor(s), polyp(s), lesion(s)**
  - 43216 hot biopsy forceps or bipolar cautery
  - 43217 snare
  - 43228 ablation, (not amenable to removal by hot bx forceps, bipolar cautery, or snare technique)
    - Esophagosscopic photodynamic therapy
**Esophagoscopy**

- Removal of foreign body - 43215

**EGD**

- In an (EGD) esophagogastro(duodeno)scopy the endoscope passes the diaphragm.
- The procedure is an EGD when the endoscope traverses the pyloric channel.
  - “Endoscope able to transverse into stomach with minimal resistance”
- Code range = 43234-43259
EGD Scenario

- The Olympus Evis endoscope was passed through the cricopharyngeus into the esophagus. The esophagus was normal. There was a small hiatal hernia. The stomach including the cardia, fundus, body and antrum was normal. The pylorus was patent and the duodenum was normal to the second portion. Patient tolerated procedure without difficulty.

- CPT code - 43235
- (If biopsy was done - 43239)

EGD

- Common procedures associated with EGD,
  - But *limited to the esophagus*:
    - 43237 endoscopic ultrasound examination
    - transendoscopic ultrasound-guided intramural biopsy
    - 43238 - FNA
  - For bleeding for *both* esophageal *and/or* gastric varices:
    - 43243 - injection sclerosis
    - 43244 - band ligation
**EGD**

- Common EGD procedures that include the esophagus, stomach, duodenum, and/or jejunum
  - 43242 US guided, intramural/transmural fine needle aspiration/biopsy(s)
  - 43239 biopsy, single or multiple
  - 43250 hot biopsy forceps or bipolar cautery removal of tumor(s), polyp(s), lesion(s)
  - 43251 snare removal of tumor(s), polyp(s), lesion(s)
  - 43258 ablation, (not by hot bx forceps, bipolar cautery, or snare)
  - 43259 US exam

**Endoscopic Control of Bleeding**

- Esophagoscopy with:
  - injection varices - 43204
  - banding of varices - 43205
  - control of bleeding - 43227

- UGI endoscopy with:
  - injection varices - 43243
  - banding of varices - 43244
  - control of bleeding, “any method” - 43255
**Insertion of PEG/PEJ Tube**

- Upper GI endoscope inserted
- Body of stomach pushed to anterior abdominal wall
- Percutaneous puncture into stomach
- Placement observed
- Balloon pulled against abdominal wall until it heals

**PEG Tube Codes**

- 43246 = EGD (endoscopic) with insertion of PEG tube
- 43750 = percutaneous gastric tube insertion
- 43760 = change of gastrostomy tube
- 43761 = repositioning of gastric feeding tube, any method, through the duodenum for enteric nutrition
- 44373 = conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube
**Biliary System Anatomy**

- **Liver**
- **Hepatic duct**
- **Pancreas**
- **Common duct**
- **Gallbladder**
- **Cystic duct**

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**ERCP**  
*Endoscopic retrograde cholangiopancreatography*

43260 - 43272

- Diagnose biliary tract disease
- Remove stones - may be used with lap chole
- Insert drains for inoperable obstruction
- May code multiple procedures
- Diagnose pancreatic disease
- Biopsy - 43261
- Sphincterotomy - 43262
- Measurements of sphincter pressure - 43263
**Endoscopy Definitions**

**CPT book -**

- **Proctosigmoidoscopy**- involves examining the rectum and sigmoid colon. 45300 - 45327
- **Sigmoidoscopy**- involves examining the entire rectum and sigmoid colon and may include examining a portion of the descending colon. 45330 - 45345
- **Colonoscopy**- involves examining the entire colon, from the rectum to the cecum, *must* include the proximal colon to the splenic flexure, and it *may* include the terminal ileum. 45355 - 45392
Colonoscopy vs. Sigmoidoscopy

- **Lengths of:**
  - Rigid sigmoidoscope is 25 cm long
  - Flexible sigmoidoscope is 50 cm long
  - Flexible colonoscope is 200 cm long

- **Definitions listed in CPT**

Sigmoid/Colon

**Sigmoidoscopy**
- diagnostic-45330-APC 146
- with biopsy(s) or cold forceps removal-45331-APC 146
- with snare removal-45338-APC 147
- with hot or cautery 45333-APC 147
- not amenable to hot or snare… - 45339-APC 147
  (APC 146 $299.34)
  (APC 147 $525.41)

**Colonoscopy**
- diagnostic 45378
- with biopsy(s) or cold forceps removal-45380
- with snare removal-45385
- with hot or cautery-45384
- not amenable to hot or snare… - 45383
  (All APC 143 $538.99)
Colonoscopy

CPT defines a colonoscopy as a procedure that has passed the splenic flexure (45355 - 45392)

Colonoscopy Scenario

- The Olympus Evis Colonoscope was inserted into the rectum and under direct vision was carefully and easily advanced to the cecum. There was an excellent prep. The cecum was identified by transillumination of light in the right lower abdomen and the ileo-cecal folds. The mucosa was carefully inspected upon removal of the colonoscope. The mucosa was normal except for internal hemorrhoids and scattered left sided diverticuli. Patient tolerated procedure without difficulty.

- IMPRESSION: Diverticulosis coli Internal Hemorrhoids

- Indication for procedure: Heme positive stool on fecal occult blood test. (Note: from clinic note 2 weeks prior - “referred to Gastroenterology for evaluation of bright red rectal bleeding per rectum in Feb 2007.”

- Code - 45378
Colorectal Endoscopy

- There are three types of colorectal endoscopy: (1) rigid sigmoidoscopy, (2) flexible sigmoidoscopy and (3) colonoscopy. Rigid sigmoidoscopy permits examination of the lower six to eight inches of the large intestine. In flexible sigmoidoscopy, the lower one-fourth to one-third of the colon is examined. Neither rigid nor flexible sigmoidoscopy requires medication and can be performed in the doctor's office.
- Colonoscopy uses a longer flexible instrument and usually permits inspection of the entire colon. Bowel preparation is required, and sedation is often used.
- The colon can also be indirectly examined using the barium enema x-ray technique. This examination uses a barium solution to coat the colon lining. X-rays are taken, and unsuspected polyps are frequently found.

Endoscopic Biopsies

- Hot biopsy
- Snare biopsy
- Cold biopsy
- Excisional biopsy
Endoscopic Biopsies

Removal of pieces of a polyp or pieces of a cancer with a biopsy forceps is “cold” biopsy - 45380.

Endoscopic Biopsies

- Removal of pieces of a sessile lesion or cancer with use of electrical current to cut and control bleeding is “hot” biopsy.

Heater probe to stop gastric ulcer bleeding
Scenario

- The mucosa was normal except for internal hemorrhoids and a raised *sessile* diminutive polyp in the sigmoid colon that was ablated via hot biopsy forceps ... 45384

Polyp
Colonoscopy with Polypectomy

Colonoscopy, flexible, proximal to the splenic flexure;
- 45383 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- 45384 with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- 45385 with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- 45380 with biopsy, single or multiple

Polypectomy

- By cold forceps/ cold biopsy forceps
- Refer to CPT Assistant
  - January 2004 and July 2004
- Polyps of various sizes can be removed using different techniques and also by different methods of removal
  - removed in its entirety and/or piece-meal removal
- Code only once for a single colonoscopy procedure regardless of whether the technique is employed on multiple polyps or multiple times on a single polyp.
Polypectomy Guidelines

- Polyp removed with a snare = snare - 45385
- Polyp removed with a cold forceps = biopsy - 45380
  - Multiple polyps removed “in toto” with a cold forceps still are coded to the biopsy code.
  - Even when polyps are in different sites of the colon and/or rectum.
  - Even when both a biopsy and a polypectomy are done on the same lesion or different lesions, using the cold biopsy forceps.

Endoscopic Polypectomy - Snare
Endoscopic Polypectomy - Snare

Removal of polyp on a stalk with use of snare - use the **snare** code - 45385.

Virtual Colonoscopy

- Newer technique
- Colon inflated with air
- High speed electron beam tomography scanner captures a few hundred slices through the abdomen
- Computer reconstructs 3-D images
- 0066T- screening
- 0067T- diagnostic
Case Study

A female patient born in 1930 was admitted to our hospital due to sustained abdominal pain and obstipation. X-ray of the abdomen revealed heavy dilatation of the colon and small intestine suggesting an obstruction of the distal colon. She refused a surgical treatment, but agreed to have a colonoscopy that was performed without prior fluoroscopy. Colonoscopy performed with a regular colonoscope (Olympus Q 145L colonoscope) showed a tumorous obstruction of the sigmoid.

http://www.biomedcentral.com/1471-230X/7/14

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Case Study

Total obstructing lesion of sigmoid. Could not get through with colonoscope - too big.
Case Study

With pediatric gastroscope, used snare, argon plasma coag to debulk tumor.

Remaining apple-core lesion of sigmoid with colon decompressed.

Case Study

A

B
Case Study

Colonoscope
Baby gastroscope
ERCP catheter
APC side fire probe
Electric polypectomy loop
Etc.

Notes/Comments/Questions
Case Study

- With obstruction relieved, patient recovered sufficiently to undergo elective study and later went to operating room for colectomy. No nodes or metastatic disease noted.
- What was done?

Case Study - Question

1. Colonoscopy with removal of tumor by snare or bipolar cautery 45384
2. Gastroscopy with biopsy single or multiple 43239
3. Proctosigmoidoscopy with ablation 45339
4. Colonoscopy with removal of tumor by snare technique 45385
Discontinued Modifiers

- See Transmittal 442 from Jan 21, 2005 for clarification of *hospital use* of modifiers 52, 73, & 74
- These modifiers are used to report procedures that are discontinued by the physician due to unforeseen circumstances that threaten the patient’s well-being.
- Modifier 53: Discontinued Procedure for Physician billing (not hospital)

Modifiers 73 and 74
Reduced or Discontinued Services

- See Transmittal 442
- Modifier 73 and 74 are used to indicate partial reduction or discontinuation of certain diagnostic and surgical procedures that *DO require anesthesia*.
- This modifier provides a means for reporting reduced services without disturbing the ID of the basic service.
- Receives either 50% (73) or full payment (74)
- “Clarifies that discontinued radiology procedures that do not require anesthesia may not be reported using 73 and 74”
- 73 and 74 are for the *hospital use only* (facility)
  - *The physician uses modifier 53 (not for hospitals)*
Hospital Reporting - Discontinued Procedures with Anesthesia

Discontinued service for procedures with anesthesia (local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general)...

Due to extenuating circumstances or those that threaten the well-being of the patient:

• 73 - after the patient had been prepared for the procedure..., *taken to the room where the procedure was to be performed*, but *PRIOR* to administration of anesthesia.”

• 74 - a surgical or diagnostic procedure requiring anesthesia was terminated *AFTER* the induction of anesthesia or after the procedure was started (incision made, intubation started, scope inserted, etc).

Modifier 52 - Reduced Service

Modifier 52 defined as stated in CPT

• Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier ‘-52,’ signifying that the service is reduced.

• This provides a means of reporting reduced services without disturbing the identification of the basic service.
Modifier 52 - Reduced Service

For hospital use
- Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers '-73' and '-74' (see modifiers approved for ASC hospital outpatient use).
- Note: For procedures without anesthesia, modifier 52 is the appropriate modifier to use.

Incomplete Colonoscopy

Physician billing: See Medicare Pub 100-4, Chapter 18, Section 60.2
- Incomplete or interrupted colonoscopies: The inability to extend beyond/ proximal to the splenic flexure
  - Applies to diagnostic and screening
  - Medicare value = same as sigmoidoscopy
  - When procedure is not completed due to an adverse event.
    - Example: Hypotensive episode
  - 45378-53
  - G0105-53
- CPT states: “For an incomplete colonoscopy with full preparation for a colonoscopy, use a colonoscopy code with modifier 52 and provide documentation”
Modifier 59 - Distinct Procedures

- Report when a second service was performed:
  - During a different session
  - At a different site
  - Distinct and different
- Colonoscopy with multiple lesions and different techniques of removal

Modifier 59 - Distinct Procedures

- Do not need for:
  - Different modes of entry such as EGD and colonoscopy
  - Different procedures that are self-explanatory or is not required
Multiple Lesion Removal Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>APC</th>
<th>SI</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>45384</td>
<td>Colonoscopy w hot biopsy</td>
<td>0143</td>
<td>T</td>
<td>538.99</td>
</tr>
<tr>
<td>45385-59</td>
<td>w snare</td>
<td>0143</td>
<td>T</td>
<td>269.50</td>
</tr>
<tr>
<td>45380-59</td>
<td>w biopsy or cold forceps</td>
<td>0143</td>
<td>T</td>
<td>269.50</td>
</tr>
<tr>
<td>43239</td>
<td>EGD w biopsy</td>
<td>0141</td>
<td>T</td>
<td>255.63</td>
</tr>
</tbody>
</table>

Without modifier 59 on 2nd and 3rd procedures, these would be bundled with error codes (39-mutually exclusive; needs modifier and 40-component of comprehensive px; needs modifier). No modifier needed for the EGD for the hospital claim, but append modifier 51 for the physician claim.

Outpatient Coding Guideline

- For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit.

- Codes for other conditions may be sequenced as secondary.
Incidental Findings

- If a physician has confirmed a diagnosis based on the results of a diagnostic test, that diagnosis should be coded.

- The signs and/or symptoms that prompted ordering the test may be reported as an additional diagnosis if they are not fully explained or related to the confirmed diagnosis.

- Incidental findings should never be listed as primary diagnosis.

Diagnostic Exam

- The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic exam, not a screening exam.

- In these cases, the sign or symptom is used to explain the reason for the test.

*Coding Clinic* 1996 4th Qtr, Article 46
**Screening Exams**

- Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for individuals who test positive for the disease.

- Compare this with a “Diagnostic Exam.”

**Screening Guide**


- When a diagnostic test is ordered in the absence of signs, symptoms or other evidence of illness or injury - (screening), the principal or first-listed diagnosis should be the reason for the test - “screening.”
Screening Guide continued

• Coding Clinic: 2004 1Q
• Should a condition be discovered during a screening, then the code for the condition may be used as an additional diagnosis.
• Report family history of conditions (malignancy) and personal history of conditions such as colon polyps (V12.72)

Colon Screening Example

• Patient seen in outpatient clinic for a screening colonoscopy-(V76.51). Patient has no personal history of gastrointestinal disease and is currently without signs or symptoms-(G0121)
• The colonoscopy revealed a colonic polyp-(211.3) which was removed by snare.
• Per AHIMA and Coding Clinic 1st Q 2004, the dx are assigned as follows:
  • 1. Screening, V76.51
  • 2. Colon polyp, 211.3

• What is the surgical colonoscopy code?
Colorectal Cancer Screening - HCPCS Codes

- Colorectal cancer screening
  - Colonoscopy
    - G0105 - high risk pt
    - G0121 - non-high risk pt
  - Flexible sigmoidoscopy - G0104
  - Both have frequency limitations

- “If during a screening colonoscopy, a lesion or growth is removed, biopsied, ..., the appropriate “diagnostic” procedure code should be billed and paid rather than code the screening code. (Mdcre, Pub 100-4, TR AB-03-114)

Colonoscopy Type?

- Screening vs diagnostic????
  - "History of pernicious anemia" is stated in the H&P and OP. "He has no grave symptoms. He was noted to be more anemic lately."
  - Documentation states that patient is "due for a surveillance colonoscopy." Patient is otherwise asymptomatic. Polypectomy was done with a hot snare.
Follow-up Exam

- If a follow-up exam is conducted to determine if there is any evidence of recurrence or mets of cancer and no malignancy is found, the case is classified to the V67 category, using the appropriate subdigit to identify the most recent mode of therapy carried out.

Follow-up Exam

- Report secondary code of “History of Malignancy” such as history of colon CA.
- If the follow-up examination reveals recurrence or metastasis, category V67 would not be used.
- Instead, the appropriate code for primary site (recurrence) or for metastatic site of malignancy would be assigned.

*Coding Clinic July/ Aug 85*
References

- **AMA’s:**
  - CPT 2007, HCPCS 2007, CPT Assistants and Coding Changes
  - Coding with Modifiers
- **AHA’s Coding Clinic**
- Taber’s Medical Dictionary
- National CCI manual, chapter 6
- **Medicare’s:**
  - Pub 100-4, Chapter 18, Section 60.2
  - Transmittals
- **Thanks to Olympus America for images of scopes and Atlanta Gastroenterology for images of pathology**
- **To view video tapings of procedures sign on to:**
  - http://dave1.mgh.harvard.edu/

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