

GASTROENTEROLOGY

CODING ALERT

The practical monthly adviser for ethically optimizing coding reimbursement and efficiency for gastroenterology practices

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Think Beyond Modifier 22 for Control-of-Bleeding Cases

► **Critical care codes can get you payment faster**

Although your gastroenterologist may justify modifier 22 on procedures involving excessive blood loss, you may be better off simply reporting a separate code — or even critical care — for control of bleeding.

Examine This Endoscopy-With-Injection Example

If the gastroenterologist uses epinephrine injection for control of bleeding during an upper GI endoscopy, you might call on 43255 (*Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method*) — in addition to the code for the primary procedure — to describe the physician's effort.

Example: The doctor injects epinephrine into a duodenal ulcer to control active bleeding during endoscopy with biopsy (43239, ... *with biopsy, single or multiple*).

In this case, if the control of bleeding adds significant physician effort, you may be tempted to report 43239 appended with modifier 22 (*Increased procedural services*).

Better way: Instead of reporting 43239-22 and struggling to provide all the additional documentation that the payer will require for a modifier 22 claim, you can accurately describe this session by reporting 43239 for the biopsy and 43255 for the control of bleeding. Code 43255 accurately describes control of bleeding by “any method,” including injection.

“I agree that it's better to report the epinephrine injections with 43255 rather than applying modifier 22” to the primary procedure, says **Doug Williams, CPC**, business office manager for Consultants in Gastroenterology SC Endoscopy Center in Columbia, S.C.

Keep in mind: On your claim, you'll report 43255 with modifier 59 (*Distinct procedural service*) and 43239. Without the modifier, payers will assume that the biopsy (or physician) caused the bleeding and bundle 43255 into 43239.

Watch Out for This Pitfall

You cannot report control of bleeding if the gastroenterologist causes the bleeding, says **Chris Harvey, LPN**, coder/charger for Visionary Enterprises Inc. in Indianapolis. You should call on control-of-bleeding codes only “when treatment is required to

control bleeding that occurs spontaneously, or as a result of traumatic injury (noniatrogenic), and not as a result of another type of operative intervention,” according to *CPT Assistant* September 1996.

Unstable Patients May Warrant Critical Care

In some cases, the patient’s condition might necessitate critical care (99291, 99292) instead of a procedure code with modifier 22.

Example: The physician plans to perform an upper GI endoscopy, but the patient has gastrointestinal bleeding so severe that the physician must suspend the endoscopy and spend 40 minutes lavaging blood from the gastro-intestinal tract before continuing.

In this situation, you should report critical care code 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*).

Don’t overdo it: You shouldn’t report a critical care code for a normal control-of-bleeding situation or if the physician causes the bleeding. In this example, however, the patient meets the definition of being critically ill

because the severity of the bleeding could be a potentially life-threatening deterioration in the patient’s condition. □

Overturn Arbitrary Gastro Edits With This Expert Advice

► Here’s what you should ask the medical director

If your claims have ever come up against irrational payer guidelines that significantly reduce your physician’s reimbursement, you probably felt powerless to change the situation.

But in some cases, you’re not powerless at all, according to **Barbara Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Tackle this gastroenterology situation, and learn two steps you can take to respond.

Have You Been in This Situation?

Example: You want to fight an insurance company for payment for 45380 (*Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple*) with 45385

Newsletter Question or Comment?



If you have a question or comment about the contents of this publication, please contact the editor, Suzanne Leder, MPhil, CPC-A, at suzannel@eliresearch.com.

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(... with removal of tumor[s], polyp[s], or other lesion[s] by snare technique).

However, they have in writing the following:

“Exceptions to Modifier 59: The following endoscopic biopsy procedures will not be allowed with the associated endoscopic therapeutic procedures: 45380 with 45383-45385.

Decision: The endoscopic biopsies with endoscopic therapeutic procedures in the same anatomical area will follow standard coding logic, and no additional reimbursement will be made for these codes even when billed with modifier 59.

Rationale: The endoscopic biopsy is an integral part of the therapeutic endoscopic procedure. Generic ClaimCheck denies the endoscopic biopsy procedure when billed with a therapeutic endoscopic procedure in the same anatomical area.”

Is there anyone who can help you get your denied claims paid? In addition, other insurances have started to deny 45380 with 45385, a combination your GI performs quite frequently. What can you do?

Fight This Decision in 3 Easy Steps

Unfortunately, the insurance company can set any rules it wants and you are forced to play by them when your physicians sign the contracts, Cobuzzi says.

Step 1: The first thing you have to do is get a copy of your contract and see what degree of latitude your payer can take relative to AMA and CMS coding rules. “If the insurer is violating what is set forth in the contract, use the contract in your appeal to fight this arbitrary policy and get it overturned,” Cobuzzi says.

Step 2: If the contract is silent on this or allows such arbitrary use of rules in favor of the payer, you should prepare to “drop the payer as one of your participating payers. Don’t have cold feet — be truly ready to drop them in this stage,” Cobuzzi says.

Step 3: Get a meeting between your physicians and the medical director. Ask the medical director to justify this policy in clinical terms as to why the insurer does not reimburse a physician for the diagnostic colonoscopy and the removal of polyps when you apply modifier 59 (*Distinct procedural service*) to indicate different sites. Explain that breaking the colonoscopy and the biopsy into multiple sessions will make the payer incur multiple facility fees, multiple anesthesia sessions as well as the physician professional fees.

If the medical director cannot explain the payer’s rationale, follow through with your threats. □

Bolster Hemorrhoid Coding Accuracy Based on Location

► Look for the 1 exception to the removal-of-multiple-hemorrhoids rule

If you didn’t know that the dentate line is the marker that separates internal hemorrhoids from external hemorrhoids, you might wind up submitting the wrong hemorrhoid-removal code.

Don’t let one piece of info send you scanning through your coding manuals — keep this hemorrhoid coding advice handy for reference instead.

Important: In all but a few cases, you will report only a single unit of a single code to describe hemorrhoid removal — even if the physician removes multiple hemorrhoids during the same session, says **Suzan Berman-Hvizdash, CPC, CPC-E/M, CPC-EDS**, physician educator for the University of Pittsburgh and past member of the American Academy of Professional Coders National Advisory Board.

Determine Hemorrhoid Location

As a first step, you must classify the types of hemorrhoids involved.

“Hemorrhoids are either internal or external,” says **M. Trayser Dunaway, MD, FACS, CSP, CHCO, CHCC**, a surgeon, speaker, coding educator and healthcare consultant in Camden, S.C. “In some cases, the physician may deal with both kinds during the same session. But

(Continued on next page)

Internal hemorrhoid symptoms: Patients with internal hemorrhoids often describe bright red spotting on the toilet tissue, or blood dripping into the toilet bowl, following defecation. They could also be asymptomatic or have complaints of discomfort, but some form of bleeding is the most common symptom among patients.

External hemorrhoid symptoms: External hemorrhoids are visible without instruments, and patients with external hemorrhoids may have complaints of discomfort, especially if the hemorrhoid has thrombosed. Bleeding usually occurs late in the course of thrombosed external hemorrhoid, after the overlying perianal skin ulcerates and the resolving, liquefied hematoma necessitates. □

whatever the circumstances, the codes you'll report are directly related to the location of the hemorrhoids involved.”

Dentate line is key: An internal hemorrhoid (which is the type gastroenterologists most often treat) originates above the dentate line (a mucocutaneous junction that lies about 1 to 1.5 cm above the anal verge). In contrast, an external hemorrhoid originates below this line. “If the physician does not directly state ‘internal’ or ‘external’ hemorrhoid, you can read further into the documentation to see if there is a reference to the dentate line,” Dunaway says. If the documentation is unclear, you should be sure to consult with the gastroenterologist before progressing.

Internal Hemorrhoids Have 4 Levels of Severity

Definition: Internal hemorrhoids occur above the dentate line and are typically lined by rectal mucosa. Rarely, acute severe bleeding requires transfusion, and, occasionally, ongoing chronic losses cause iron-deficiency anemia.

There are four types of internal hemorrhoids:

First degree: The hemorrhoid does not protrude from the anus.

Second degree: The hemorrhoid protrudes from the anus during a bowel movement and returns to the anal canal.

Third degree: The hemorrhoid protrudes from the anus during a bowel movement but can be pushed back into the anus.

Fourth degree: The hemorrhoid is always outside the anus and cannot be pushed into the anal canal.

Focus on These Internal-Hemorrhoid-Removal Codes

When the gastro removes internal hemorrhoids, he will usually use one of the following methods:

- rubber-band ligation (46221, *Hemorrhoidectomy, by simple ligature [e.g., rubber band]*)
- sclerotherapy (46500, *Injection of sclerosing solution, hemorrhoids*)
- infrared cautery (IRC) (46934, *Destruction of hemorrhoids, any method; internal; 46936, ... internal and external*).

Other methods: You would likely code any other method for internal hemorrhoid removal with 46934 and/or 46936 (*Destruction of hemorrhoids, any method; internal and external*).

Think External When Thrombosis Hits

Although gastroenterologists mainly treat internal-hemorrhoid patients, GIs may also treat external ones, especially if the patient has a thrombosed external hemorrhoid. External hemorrhoids occur below the dentate line and are usually covered with squamous epithelium.

Methods/codes used: The physician will likely use one of these methods to treat external hemorrhoids:

- incision (46083, *Incision of thrombosed hemorrhoid, external*)
- cauterization (46935, *Destruction of hemorrhoids, any method; external; and/or 46936*).

Exception: Unlike other methods, the incision of a thrombosed hemorrhoid (46083) describes only one removal.

Code for any other method of external-hemorrhoid removal with 46935 and/or 46936. Before filing a claim with these codes for any removal technique other than cauterization of external hemorrhoids, contact the payer. □

Apply New ABN Form by Sept. 1

► **Heads up: These 3 principles remain the same**

CMS has unveiled its new advance beneficiary notice (ABN), and even though the hard deadline is several months away, you should take steps now to put it into practice.

Good news: The new ABN not only replaces the previous ABN-G (for physicians) but also incorporates the notice of exclusion from Medicare benefits (NEMB) form. CMS expects this new, combined form to “eliminate any widespread need for the NEMB in voluntary notification situations,” according to the new ABN Form Instructions document.

The NEMB’s previous purpose: In case you weren’t familiar with exactly when you were supposed to use the ABN rather than the NEMB, keep in mind that in the past, ABNs were only for procedures that Medicare might not cover but didn’t apply to procedures that were statutorily excluded from Medicare benefits. That was where the NEMB came in — you were able to use it for services such as cosmetic surgery, which Medicare never covered.

Now CMS will accept the new ABN form for either purpose, noting in its ABN Instructions that “the revised version of the ABN may also be used to provide voluntary notification of financial liability.”

Don’t worry: Although Medicare carriers began accepting the new ABN form as of March 3, CMS has implemented a six-month transition period. Therefore, you aren’t required to submit the new form until Sept. 1.

Although the ABN form has changed, many of the previous ABN “best practices” remain the same. Following is a quick look at three important ABN facts.

All Hail the Importance of the ABN

If you discover that a patient’s upcoming procedure is not payable by Medicare but the patient still wants you to perform the service, the ABN will let the patient know that he may be responsible for paying the noncovered portion.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay for it. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare refuses to pay. Without a valid ABN, you cannot hold a Medicare patient responsible for the denied charges, says **Kara Hawes, CPC-A**, coder with Advanced Professional Billing in Tulsa, Okla.

“The patient has to sign the ABN form at the time of service, otherwise the form is not valid,” Hawes says. “When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient.”

You Be the Coder

Hydrogen Tests Can Diagnose Many Conditions

Question: *When a gastroenterologist performs a hydrogen breath test, what are some acceptable conditions to test for? I thought the test was only used to check for a lactase deficiency.*

North Carolina Subscriber

Answer: See page 55. □

Explain the ABN to the Patient

ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the procedure in question; 2) cancel the procedure; or 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure.

Explain ABN Status With a Modifier

When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare’s explanation of benefits (EOB) will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

“The GA modifier (*Waiver of liability statement on file*) is used when the service provider believes the service is not covered and the office has a signed ABN on file,” says **Dena Rumisek**, biller with Grand River Gastroenterology PC, in Grand Rapids, Mich. This might include tests ordered without a payable diagnosis code or those ordered more frequently than covered.

Modifier GY (*Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit*) applies when Medicare excludes the service and you’re using the new ABN as you would have used the NEMB in the past.

Modifier GZ (*Item or service expected to be denied as not reasonable and necessary*) means that you didn’t issue an ABN when you probably should have, and you cannot bill the patient when Medicare denies the service.

Apply These Principles to Gastro Example

On occasion, an asymptomatic patient may request a colonoscopy that does not meet Medicare’s screening requirements. In such cases, your best bet to collect payment is to bill the patient directly for the service.

For instance: A covered Medicare patient younger than 50 years of age with no apparent symptoms and low-risk factors may ask for a screening “just to be sure,” or a high-risk beneficiary who has had an exam within 18 months may request an exam for similar reasons.

To ensure that the patient understands that he will be responsible for payment, you should request that he read and sign an ABN. You should present the patient with the

(Continued on next page)

ABN well in advance of the procedure and explain to the patient why Medicare will likely deny the service.

Remember: “An ABN tells the patient it’s likely that Medicare won’t cover the service, and therefore it will be the patient’s responsibility to pay if the service is uncovered,” says **Cecile M. Katzoff, MGA**, vice president for consulting services at the American Gastroenterological Association and the director of the AGA Center for GI Practice Management and Economics. “The patient can then determine whether or not he wants to have the procedure done, given the fact it’s likely he will have to pay for it.”

Medicare does not mandate that you use ABNs, but it does prohibit billing a Medicare beneficiary for a denied claim unless the doctor’s office has a signed ABN. The ABN proves to Medicare that the patient understands that he might be responsible for the bill, Katzoff says.

Note: For more information on the new ABN form, visit www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage. □

READER QUESTIONS

Part Peritoneocentesis Sessions on Claims

Question: *The gastroenterologist performed peritoneocentesis on a patient to drain fluid from his abdominal cavity. The sessions were two days apart, but I’m curious about how to report the encounters. Can we code for both the initial and subsequent peritoneocentesis on the claim?*

California Subscriber

Answer: Yes, you can. When you file the claim, you should:

- report 49080 (*Peritoneocentesis, abdominal paracentesis, or peritoneal lavage [diagnostic or therapeutic]; initial*) for the first session.
- report 49081 (... *subsequent*) for the second session.

Heads-up: Physicians often perform peritoneocentesis (also known as abdominal paracentesis or peritoneal lavage) over several sessions. CMS prohibits reporting both codes on the same date, but if you report 49080 and 49081 on different dates of service, the insurer should not bundle the codes.

Also, when your gastro performs peritoneocentesis with imaging guidance, you may be able to report these codes:

- 77012 — *Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation*
- 76942 — *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), image supervision and interpretation.*

Note: Check with the individual payer for its imaging guidance policy before filing a peritoneocentesis claim with 76360 and/or 76942 included.

Reporting Both 45378 and G0105 Spells Trouble

Question: *Our gastroenterologist performed a colonoscopy for a rectal bleed on a Medicare patient. The patient also has a family history of colon cancer. Should I report both 45378 and G0105?*

Kentucky Subscriber

Answer: No, you should not report both 45378 (*Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]*) and G0105 (*Colorectal cancer screening; colonoscopy on individual at high risk*). Each of these codes describes colonoscopy, and reporting them both during the same session would be double-billing.

In this case, the colonoscopy is diagnostic rather than screening, with a primary diagnosis of 578.1 (*Blood in stool*). Therefore, you should report 45378 only. You may, however, cite V16.0 (*Family history of malignant neoplasm; gastrointestinal tract*) as a secondary diagnosis.

Find Your Secca Coding Solution Here

Question: *How can we report use of the Secca System to treat several fecally incontinent patients? I can’t find a code in CPT. Can we still receive reimbursement?*

New Mexico Subscriber

Answer: You won’t find a code for the Secca System because CPT doesn’t contain one. Therefore, your best code selection is 46999 (*Unlisted procedure, anus*).

When submitting an unlisted-procedure code, you must include full documentation describing the procedure so the payer can make a coverage determination.

Receiving payment for the Secca System will prove much more difficult than coding it. The FDA approved Secca — which delivers radiofrequency energy into the muscle of the anal sphincter to improve its barrier function — for the treatment of fecal incontinence (for instance, 307.7, *Encopresis [continuous] [discontinuous] of nonorganic origin*; or 787.6, *Incontinence of feces*) in 2002. But most payers still treat the technique as experimental and therefore will not cover it.

Aetna, for one, says it “considers transanal radiofrequency therapy for the treatment of fecal incontinence (also known as the Secca procedure) experimental ... because its effectiveness has not been established.” Many payers (including Medicare) observe similar guidelines.

You Be the Coder

Hydrogen Tests Can Diagnose Many Conditions

Answer: The parameters governing hydrogen breath tests have changed over time, and gastroenterologists can get paid for lactase deficiency checks in addition to several other conditions. For instance, in CPT 2005, the AMA amended hydrogen breath test rules to include testing for fructose intolerance, bacterial overgrowth, or orocecal gastrointestinal transit.

Whenever a gastroenterologist performs a hydrogen breath test to check for any of these conditions, report 91065 (*Breath hydrogen test [e.g., for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or orocecal gastrointestinal transit]*).

Example: A patient with chronic diarrhea reports for a hydrogen breath test. On the claim, you should report 91065 for the test and attach 787.91 (*Diarrhea*) to 91065 to represent the patient’s diarrhea.

Remember: You should not use 91065 to report an *H. pylori* breath test analysis. Report those with:

- 83013 — *Helicobacter pylori*; breath test analysis for urease activity, non-radioactive isotope (e.g., C-13) or
- 78268 — *Urea breath test, C-14 (isotopic); analysis.* □

Payment tip: If the gastroenterologist thinks that Secca is the best treatment option and the patient wishes to proceed, you should ask the patient to sign an advance beneficiary notice (ABN) prior to providing the service. This form will make the patient aware that he will be responsible for payment if the insurer rejects the claim.

Expect More Money From In-Office Procedure

Question: *What is the difference between facility and nonfacility relative value units (RVUs)?*

Kansas Subscriber

Answer: CMS assigns codes facility and nonfacility RVUs based on where the physician provides the service. You’ll see this variation in RVUs called “site-of-service differential.”

Nonfacility RVUs are used to calculate payment when the gastroenterologist provides a service in the office or clinic. CMS applies facility RVUs when the gastroenterologist provides a service in a hospital or ambulatory surgery center.

The higher the RVUs, the more money your office can expect for the procedure or service. Nonfacility RVUs usually pay at a higher rate than facility RVUs because they include the expenses required to perform the procedure within an office setting.

For example, the gastroenterologist performs a colonoscopy with a submucosal saline injection (45381, *Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection[s], any substance*). If the physician performs this procedure in the office, the RVUs are 12.22, but RVUs for the same procedure performed at a hospital are 6.65. These are the national average without figuring in the geographical cost.

Maximize Your Multiple Polyp Coding Knowledge

Question: *Our office has two coding questions about removing polyps via colonoscopy. Many times, our gastroenterologist will remove several polyps using the same technique. Less frequently, the gastro also treats polyps with different removal methods during the same visit. Can I report multiple codes in these office situations?*

Missouri Subscriber

(Continued on next page)

Answer: When the physician performs a colonoscopy to remove more than one polyp during the same patient encounter using the same method, you cannot report multiple codes

Explanation: CPT designed all polyp-removal codes for use once per session regardless of the number of polyps removed.

Suppose the gastro removes and cauterizes three polyps during a colonoscopy using a hot biopsy forceps. You should report 45384 (*Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery*) once for the encounter.

In the above scenario, if the gastro ablated one polyp with an argon plasma coagulator (APC), then removed the other two by snare technique, you would:

- report 45383 (*Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*) for the APC ablation.
- report 45385 (... *with removal of tumor[s], polyp[s], or other lesion[s] by snare technique*) for the polyp removal with the snare.
- attach modifier 59 (*Distinct procedural service*) to 45385 to show that the APC ablation and the snare technique removal were two distinctly different procedures.

Remember: On the claim, also be sure the documentation supports two removal methods and explains why the physician needed to perform both methods.

— *Clinical and coding expertise for this issue provided by Michael Weinstein, MD, a gastroenterologist in Washington, D.C., and former member of the AMA's CPT Advisory Panel; and Linda Parks, MA, CPC, CMC, CMSCS, an independent coding consultant in Atlanta.* □

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