The Coding Institute

Gastroenterology Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency for gastroenterology practices

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Don't Wait for New CPT Codes; Maximize Virtual Colonoscopy Payment Now

▶ ***Learn whether to file an ABN with 0066T, 0067T.***

CMS is set to decide in February whether it will grant national coverage for virtual colonoscopies to screen for colon cancer. But when your gastroenterologist uses the latest technology for diagnostic work — under the right circumstances — you can bill right now for computed tomography colonography.

When All Else Fails

Some Medicare carriers, such as Palmetto GBA, accept category III (temporary) codes 0066T (*Computed tomographic [CT] colonography [i.e., virtual colonoscopy]; screening*) or 0067T (*... diagnostic*), as appropriate, for so-called "virtual" colonoscopy, also known as CT colonography (CTC).

Even then, you'll have to document a failed "instrument colonoscopy" to expect reimbursement for virtual colonoscopy claims.

"CT colonography is only indicated in those patients in whom an instrument colonoscopy of the entire colon is incomplete despite adequate patient preparation, this episode or in past episode(s)," says Palmetto's policy, or "a history of adverse event with instrument colonoscopy (i.e., perforation), or a clearly documented condition which is incompatible with colonoscopy such as barium enema demonstrating highly tortuous colon, severe strictures, etc."

"There are some unfortunate patients we come across for whom, due to unique contraindications or other complications, this is their best and only diagnostic tool," says **Debbie Rooth, CPC, LVN,** who works for Mission Internal Medical Group in Mission Viejo, Calif. It's nice to have that much clarity in a local coverage determination, she says; while Palmetto isn't endorsing wide-spread CTC use, "they're explaining why, in some rare cases, it is a valid examination."

Caution: Coverage for 0066T and 0067T is far from universal, with many Medicare carriers holding out. The bottom line? Check with your carrier for coverage before reporting these codes.

"We have to appeal pretty much every diagnostic one that we perform, even when we have the documentation or the diagnosis code to support it," says **Kelli Pekios,** patient accounts manager at Gastroenterology Consultants SC in Moline, Ill. "It is a lot of work, but we do manage to get them paid."

What is virtual colonoscopy: CT colonography (virtual colonoscopy) is an enhanced abdominal CT scan in which computerized reconstruction allows physicians to perform a detailed, 3-D examination of the bowel for polyps, cancer, or other disease.

Carefully Document Medical Necessity

Supporting diagnoses: For 0066T, you would use V76.51 (*Special screening for malignant neoplasms; colon*).

For 0067T, you would provide V64.3 (*Procedure not carried out for other reasons*) when the physician attempted an instrument colonoscopy but did not complete the service **or** when the physician determines that he cannot safely attempt an optical colonoscopy. And you'll need to provide a secondary diagnosis as a reason the physician could not carry out the procedure. For instance, your documentation might support 211.3 (*Benign neoplasm of colon*) as your second diagnosis.

Payers will expect you to have documentation for **both** the virtual colonoscopy and the failed colonoscopy available upon request.

Components: These Category III codes include both the technical (modifier TC, *Technical component*) and physician-reading fee (modifier 26, *Professional component*). Odds are, your practice doesn't own a CT scanner, so you would bill only for the professional component, while the facility bills for the technical component.

In Rooth's case, her large, multi-specialty clinic recently bought a CT scanner. The gastroenterologists will contract with a radiology group to do the interpretations, she says, "while we bill the technical component."

Make Sure Patient Knows He's On the Hook

Modifier GA (*Waiver of liability statement on file*) should let Medicare know you have an Advance Beneficiary Notice (ABN) on file.

Example: A patient opts for a screening virtual colonoscopy, so your practice makes sure to get an ABN on file. The ABN instructs the patient that you suspect Medicare won't pay for the service and the patient must choose whether he is willing to receive the service knowing he may have to pay.

The ABN should include an estimate of the cost, and you should have the patient sign and date the document. You report 0066T and append GA.

Tip: If you don't get a signed ABN, append modifier GZ (*Item or service expected to be denied as not reasonable and necessary*) to let Medicare know you're aware the payer is unlikely to cover the service but you don't have an ABN.

Ensure that you don't obtain "blanket" ABN forms from all or most of your patients. You should only obtain

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New form: Make sure you're using the most up-to-date ABN form. A new form goes into effect in March. You can find the new ABN form and filing instructions at www.cms.hhs.gov/BNI. Click on the link for "FFS ABN-G and ABN-L," then download the forms and instructions for "Revised ABN CMS-R-131."

Is CTC the Future of Screening?

Medicare does not cover 0066T, the CTC code for screening. However, many think this may soon change. On March 5, 2008, the American Cancer Society, the U.S. Multi Society Task Force on Colorectal Cancer, and the American College of Radiology recommended CTC as an option for colorectal cancer screening.

Background: "Virtual colonoscopy is poised to become the procedure of choice for mass screening for colonic polyps," says Stony Brook University's **Arie Kaufman, PhD,** in a press release. Kaufman developed CTC technology at Stony Brook University in Stony Brook, N.Y.

"If all patients 50 years of age and older will participate in these screening programs, over 92 percent of colorectal cancer will be prevented and more than 600,000 lives could be saved worldwide every year through this early detection," Kaufman said.

The American Gastroenterological Association still places its highest faith in a scope. "The AGA Institute supports optical colonoscopy as the definitive screening test for colon cancer," according to gastro.org. "We also support CT colonography and other screening tests, if patients and their physicians believe the alternative test is the appropriate one for them." ❑

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Develop a System to Deliver the Best Bang for Your PQRI Buck

▶ ***A coder shares lessons learned from the first two years.***

If you really want that 2 percent bonus for taking part in Medicare's Physician Quality Reporting Initiative, your whole office must buy in to the effort, and you need a plan to boost your chances to earn that extra money, our experts say.

There's no secret formula to winning the PQRI sweepstakes, says **Tracy Helget, CPC,** of Medical Associates of Manhattan in Manhattan, Kan., "but you need to develop a system that all providers and nurses can follow." Helget's office has been taking part in PQRI since its inception in 2007.

Helget is using lessons learned from her first year's PQRI reports to develop a system she hopes will enable all of her 17 providers (including a gastroenterologist) to qualify for the bonus in 2009.

Remember: To qualify for the PQRI bonus, your provider must report on 80 percent of qualifying visits on at least three criteria.

Get in Front of PQRI Now

Helget breaks it down for you:

Lesson 1: Identify all your Medicare fee-schedule patients. These should include the replacement Medicare plans, such as Humana Gold and Advantra Medicare. This may seem obvious, but if you miss a qualifying patient on the front end, you can't catch up later, because the PQRI code must accompany the appropriate E/M or procedure code when you report.

Lesson 2: Do your homework to keep the labor down for the rest of the year. "Don't report on what you see the most; this will require way too much additional paper-work," Helget says.

Narrow your list: Before you get started, review the qualifying criteria of each measure, Helget says. Eliminate any that would never apply to your practice. Eliminate the next set of measures based on diagnosis codes. Then choose five to report. You only need to successfully report three criteria, but five gives you room for error, Helget says.

If your billing system is capable, run reports based on diagnosis code, limited to the Medicare carriers, of the E/M visits you've performed in the past year. Most of the PQRI measures require an E/M visit as qualifying criteria.

(Continued on page 29)

Quality measure of interest to gastroenterologists (patients 18 and older)	CPT II codes	ICD-9 codes	E/M or procedure codes
83. Hepatitis C: Confirmation of Hepatitis C Viremia (HCV)	3265F — *Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented* AND 1119F — *Initial evaluation for condition* AND 1121F — *Subsequent evaluation for condition*	070.51 070.54 070.70	99201-99205, 99212-99215, 99241-99245, 99354-99355
84. Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Therapy	3218F — *RNA testing for hepatitis C documented as performed within six months prior to initiation of antiviral treatment for hepatitis C* AND 4150F — *Patient receiving antiviral treatment for hepatitis C* OR 4151F — *Patient not receiving antiviral treatment for hepatitis C*	070.54	″
85. HCV Genotype Testing Prior To Therapy	3266F — *Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for hepatitis C* AND 4150F — *Patient receiving antiviral treatment for hepatitis C* OR 4151F — *Patient not receiving antiviral treatment for hepatitis C*	070.54	″
86. Hepatitis C: Antiviral Treatment Prescribed	4152F — *Documentation that combination peginterferon and ribavirin therapy considered* OR 4153F — *Combination peginterferon and ribavirin therapy prescribed*	070.54	″
87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	3220F — *Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment* AND 4150F — *Patient receiving antiviral treatment for hepatitis C* OR 4151F — *Patient not receiving antiviral treatment for hepatitis C*	070.54	″
89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	4158F — *Patient education regarding risk of alcohol consumption performed*	070.51 070.54 070.70	″
90. Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	4159F — *Counseling regarding contraception received prior to initiation of antiviral treatment* AND 4150F — *Patient receiving antiviral treatment for hepatitis C* OR 4151F — *Patient not receiving antiviral treatment for hepatitis C*	070.54	″
183. Hepatitis C: Hepatitis A Vaccination in Patients with HCV**	4154F — *Hepatitis A vaccine series recommended* 4155F — *Hepatitis A vaccine series previously received* 3215F — *Patient has documented immunity to hepatitis A*	070.51 070.54 070.70	″
184. Hepatitis C: Hepatitis B Vaccination in Patients with HCV**	4156F — *Hepatitis B vaccine series recommended* OR 4157F — *Hepatitis B vaccine series previously received* OR 3216F — *Patient has documented immunity to hepatitis B*	070.51 070.54 070.70	″
113. Preventive Care and Screening: Colorectal Cancer Screening	3017F — *Colorectal cancer screening results documented and reviewed*	V76.51	99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337

Of these, choose your PQRI based on diagnosis codes that you see only a few of each year. "I recommend to our providers that they choose the PQRI that had fewer than 10 reportable incidents in 2007."

Minimize paperwork: If it works out right, Helget says, each provider should have to complete fewer than 50 reports over the year to qualify for the bonus. "It isn't foolproof," she says, but it's a place to start.

Lesson 3: Make it a team project. The front desk needs to flag the Medicare patients at the time of the visit. The nurses and providers need to identify the diagnosis criteria that will qualify the visit. If your physician forgets to complete the report or the report gets separated from the charge-billing information, Helget says, your opportunity is gone.

"All staff will have to be diligent to make it work," Helget says.

Patience, Thoroughness Are Keys to Success

Dealing with complexity and bureaucracy are the two big PQRI challenges, Helget says. "Many providers feel the PQRI reporting is too confusing and overwhelming so they won't attempt it," she says.

Another frustration is not knowing your results until it's too late to correct your processes. CMS's gears grind slowly. "Unfortunately, the (Medicare) reports were not available to us early enough to help with changes for the 2008 reporting year," Helget says. "Having the first year's reports has definitely been helpful in finding a direction to move in for the next year."

**** Paired:** Measures 183 and 184 must be reported together.

More codes: Additional measures that gastroenterologists may report include 124. Health Information Technology (HIT): Adoption/Use of Electronic Health Records, 130. Documentation and Verification of Current Medications in the Medical Record, and 185. Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate

Useful tool: Download PQRI data-collection sheets and learn more from the AMA at www.ama-assn.org/ ama/pub/category/20358.html

How to Do PQRI

You have to do a little extra coding for PQRI participation, says **Caral Edelberg, CPC, CCS-P, CHC,** president of Medical Management Resources for TeamHealth in Jacksonville, Fla. "There are specific PQRI quality-data codes associated with each of the PQRI measures," she says. The PQRI quality-data codes are mostly CPT Category II codes, located in the back of CPT 2009 and in Appendix H, where CPT lists the measures alphabetically by clinical condition or topic. PQRI relies on some HCPCS codes, too. Here's the PQRI process for each patient your office sees:

- Check to make sure he is a Medicare fee-schedule patient
- Review documentation to determine if treatment is consistent with one or more of the PQRI measures you've chosen to report
- Assign the CPT and ICD-9 codes as you would normally for the claim.
- Check to make sure your ICD-9 and CPT codes match the measure's requirements (see chart)
- Assign the appropriate Category II or HCPCS code, and any modifiers that you need.

Even if your gastroenterologist doesn't perform a PQRI service, you should still report the appropriate code for an eligible case. You just append a PQRI modifier to explain why your doctor didn't perform the service:

(Continued on next page)

You Be the Coder

Can You Remove All Doubt About This Stent Removal?

__Question:__ *My physician gave me charges for an EGD with foreign-body removal connected to diagnosis of 936. He also performed a gastric biopsy with cold forceps for acute gastritis without obstruction. In the op note, he states that the foreign body is a plastic biliary stent that was properly positioned in the papilla and that he removed it with a snare.*

He wants me to use 43247 for the procedure. My dispute is that he went into the papilla to remove the stent, which I think 43269 better describes. If he had removed the stent from the stomach or any other area I would agree with 43247. What codes are appropriate for this case?

Utah Subscriber

__Answer:__ Turn to page 31. ❑

- 1P — *Performance measure exclusion modifier due to medical reasons*
- 2P — *Performance measure exclusion modifier due to patient reasons*
- 3P — *Performance measure exclusion modifier due to system reasons*
- 8P — *Performance measure reporting modifier — action not performed, reason not otherwise specified.* ❑

Reader Questions

Call on Injection Code for Pre-Surgical Marking

Question: *What procedure code should I use for a flexible sigmoidoscopy to 15 cm and only done to tattoo a lesion that was found on an earlier procedure? This marked area will be removed at another procedure in the near future.*

South Carolina Subscriber

Answer: Use 45335 (*Sigmoidoscopy, flexible; with directed submucosal injection[s], any substance*). You can use the injection codes for a variety of substances the physician injects into the intestinal mucosa. This includes saline to lift a polyp, epinephrine to stop bleeding, botox for sphincter spasm, solumedrol for strictures, or India ink for tattooing of cancerous lesions.

❑

Use Benign-Lesion Code for Stoma Repair

Question: *Our gastroenterologist treats a patient who has a gastrostomy tube. The op note says the patient has "some issues with granulation tissue at the stomal site that gets irritated and bleeds." The physician performed "argon plasma photoablation of granulation tissue at stomal site." How should I code this diagnosis and procedure?*

Delaware Subscriber

Answer: Use code 17110 (*Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions*) for the procedure. Link that to a diagnosis of 701.5 (*Other abnormal granulation tissue*).

Code 17110 doesn't specifically mention plasma ablation, but the wording doesn't rule it out, either. Gastroenterologists usually use argon plasma coagulation — a jet of ionized gas — to treat bleeding inside the body.

❑

2 Codes Needed for Capsule Placement, Reading

Question: *What is the code for placing a small bowel capsule by way of an EGD?*

Louisiana Subscriber

Answer: You'll code 43235 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]*) for the EGD and 91110 (*Gastrointestinal tract imaging, intraluminal [e.g., capsule endoscopy], esophagus through ileum, with physician interpretation and report*) for his interpretation of the wireless capsule data.

Take care: For 91110, make sure your place of service is where the capsule's data was downloaded. If it's your practice's equipment and capsule (and not a facility's), check that your place of service was the office (11). If a facility provided the capsule, then append modifier 26 (*Professional component*) to 91110 — you can code only for the professional component of the service. Some carriers require you to append modifier 52 (*Reduced services*) on 91110 when it is placed by EGD.

The description states from the “esophagus through ileum,” and if the capsule is placed in the stomach, it did not record the esophagus.

❑

What’s the Code for Weight Loss After Gastrectomy?

Question: *I need a code for a patient with weight loss and history of gastrectomy. Should I use 579.3?*

Maine Subscriber

Answer: If your physician documents that the patient is eating but still losing weight, then yes, use 579.3 (*Other and unspecified postsurgical nonabsorption*). Otherwise — for instance, if the patient has lost appetite — use 783.21 (*Loss of weight*).

Patients frequently have trouble digesting and absorbing their food after gastric surgery. The reduced size of the stomach causes inadequate mixing of food with digestive juices (579.3).

Bacterial contamination in a cut-off “blind loop” in the small intestine (due to a gastroenterostomy) may cause maldigestion (579.2, *Blind loop syndrome*).

Gastric surgery that allows food to enter into the upper small intestine with minimal digestion may reveal mild celiac disease (which, when severe, would merit 579.0, *Celiac disease*).

❑

You Be the Coder

(Question on page 29)

Can You Remove All Doubt About This Stent Removal?

Answer: Just code for the EGD with biopsy (43239, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple*).

To bill ERCP with removal (43269, *Endoscopic retrograde cholangiopancreatography [ERCP]; with endoscopic retrograde removal of foreign body and/or change of tube or stent)* your gastroenterologist must:

- perform an ERCP including the contrast imaging of the bile duct or pancreatic duct ,and/or
- replace the stent.

He didn’t do either; he just removed the stent. Code 535.00 (*Acute gastritis without mention of hemorrhage*) for the primary diagnosis.

The Correct Coding Initiative (CCI) stipulates, “CPT codes such as 43247 should not be reported for routine removal of previously placed therapeutic devices.” ❑

Sounds Like 2 Procedures, but Use Just 1 Code

Question: *My physician’s note says “EGD with removal of a dysfunctional PEG tube and placement of a 20 French U.S. endoscopy PEG tube.” How should I code these?*

Rhode Island Subscriber

Answer: The correct code is 43246 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube*).

Your gastroenterologist is replacing a feeding tube that runs through the patient’s skin straight into the stomach. The removal of the old percutaneous endoscopic gastrostomy (PEG) tube is incidental to its replacement, so you just need one code.

❑

Photography Is Part of the EGD

Question: *My provider is billing an EGD, and in his op report he states that he obtained photo documentation. Is this something we can bill for?*

Oklahoma Subscriber

Answer: No. Just bill the appropriate EGD procedure, for instance 43235 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]*).

Any pictures your physician took are just part of the diagnostic procedure. The same is true with many supplies and services considered integral to a surgical procedure:

- cleansing, shaving, and prepping of skin
- draping of patient, positioning of patient
- insertion of intravenous access for medication
- sedative administration by the physician performing the procedure

(Continued on next page)

• local, topical or regional anesthetic administered by the physician performing the procedure

• surgical approach, including identification of anatomical landmarks, incision, evaluation of the surgical field, lysis of simple adhesions, isolation of neurovascular, muscular (including stimulation for identification), bony or other structures limiting access to the surgical field

• preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, transcription

• surgical supplies, unless excepted by policy.

❑

Look for More Details on 'Mucosal Resection'

Question: *What is the code for endoscopic mucosal resection?*

Kentucky Subscriber

Answer: If your physician is removing a polyp or lesion, use the appropriate endoscopy code, such as 43251 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique*).

There is no procedure code for "endoscopic muscosal resection." A resection is just the partial removal of a bodily structure, in this case the lining of the esophagus, stomach, or intestines. It's less aggressive than an "-ectomy." Look to what's being treated to see if there's a more specific procedure code; if not, you may be stuck with an unlisted procedure such as 43499 (*Unlisted procedure, esophagus*).

— 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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