How to effectively code for Endoscopic procedures in Gastroenterology

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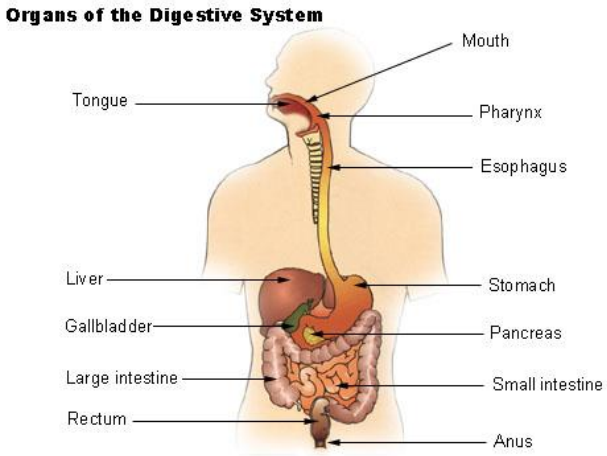
Objectives

- Diagnosis and Terminology used in endoscopic procedure in gastroenterology
- Basic and advanced endoscopy procedures and techniques in gastroenterology (videos) will be shown for each procedure)
- Current CPT & ICD-10 coding instruction
- "Multiple Endoscopy Reimbursement"

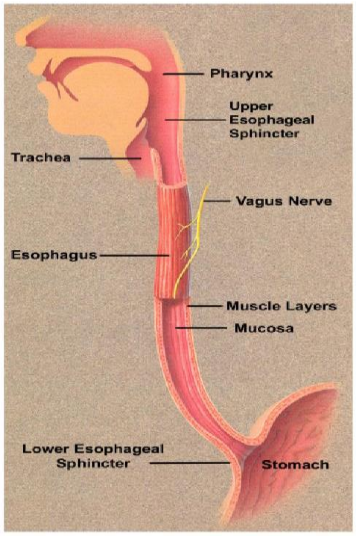
Location

“If it isn’t documented, it doesn’t exist”

Anatomy



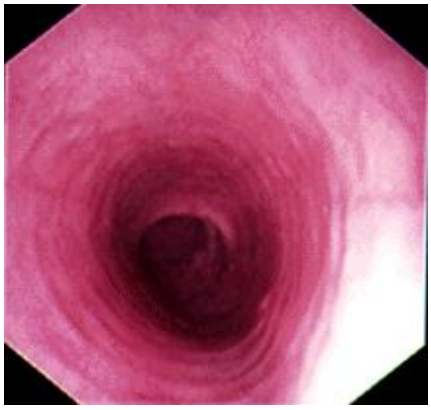
Esophagus



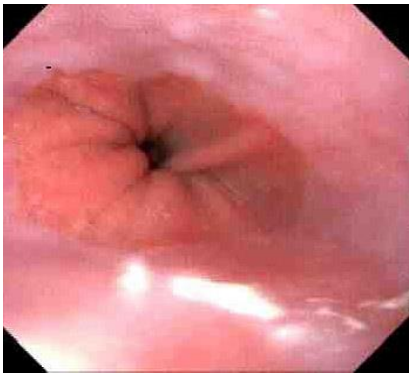
- Pharynx
- Upper esophageal sphicter (UES)
- Upper esophagus
- Middle esophagus
- Lower esophagus
- Lower esophageal sphincter (LES)

Most common endoscopic report using Location by distance from incisors (CM)

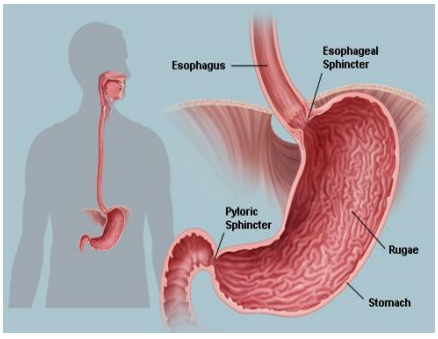
Normal esophagus – endoscopic view

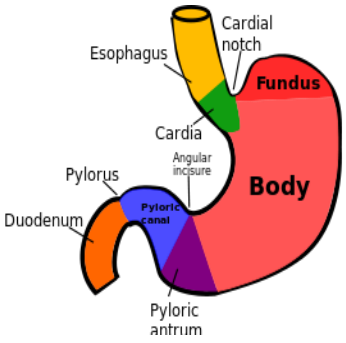


Lower esophageal sphincter (LES) endoscopic view



Stomach - Gastric

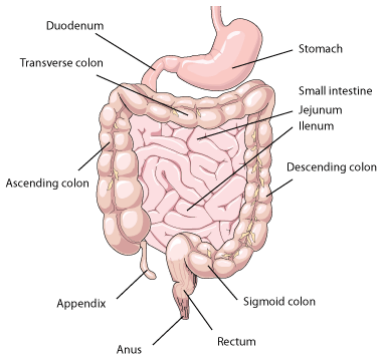




Stomach Endoscopy

- Video file

Small Bowel : Small Intestine



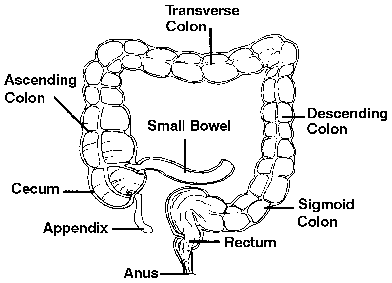
- Duodenum
  - Duodenal Bulb
  - 2nd part of duodenum

(Upper endoscopy ends here)

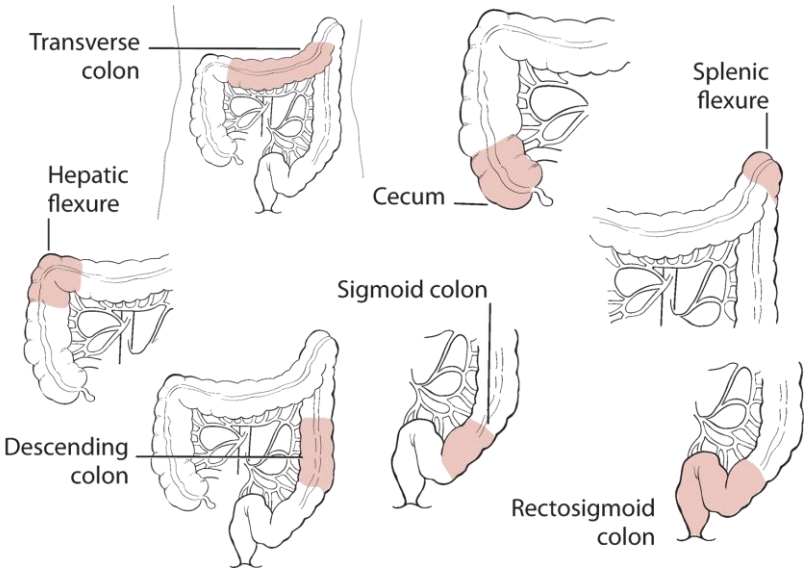
  - 3rd part of duodenum
  - 4th part of duodenum
- Jejunum
- Ileum
  - Terminal Ileum

(Enter from colonoscopy)

Colon : Large Intestine



- Endoscopy report using location by landmark or distance from anus (cm)
- ICD 10 is very specific to the location, especially for polyps.
- This is an important key for coding for multiple procedures for polypectomy.



ICD 10 code for polyps

211.3 Benign neoplasm of colon

- 10 **D12.0** Benign neoplasm of cecum
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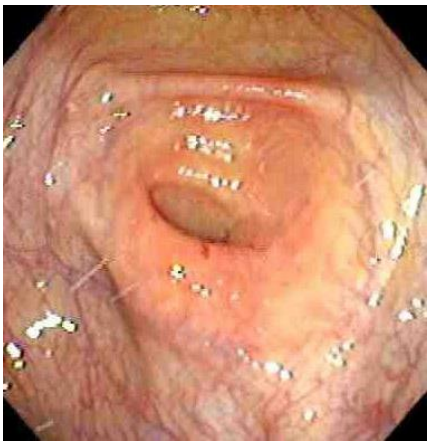
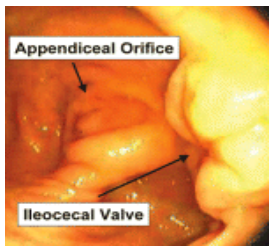
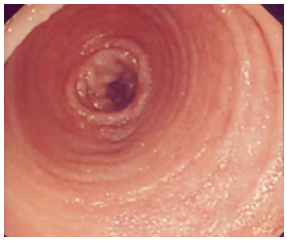
Anatomical Landmark in colon

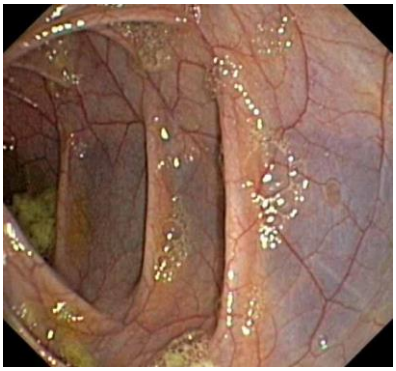


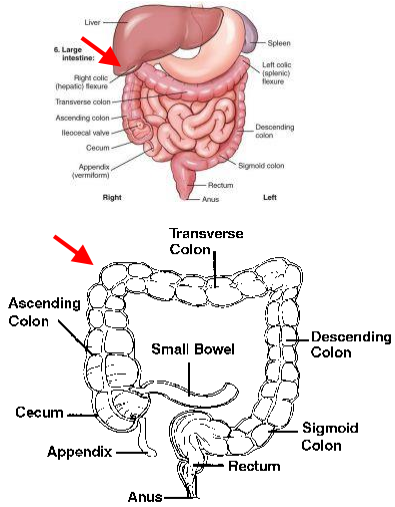




Anatomical Landmark in colon

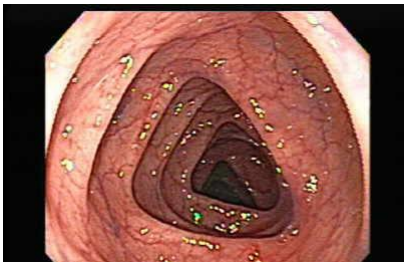
Hepatic flexure

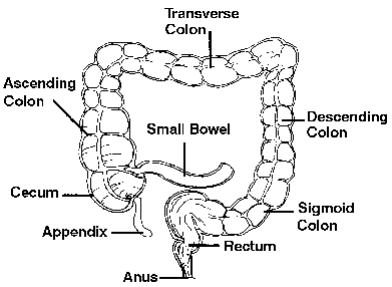




Anatomical Landmark in colon

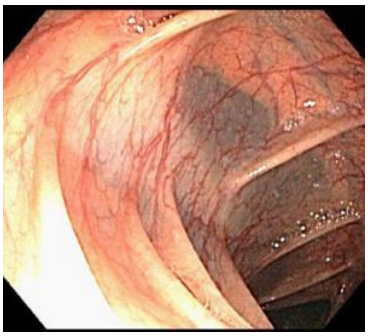
Transverse colon

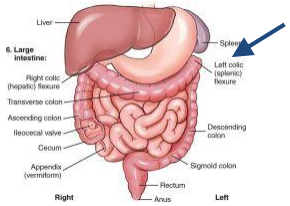


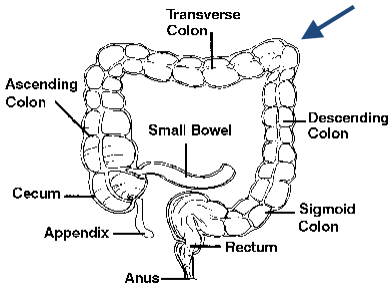


Anatomical Landmark in colon

Splenic flexure

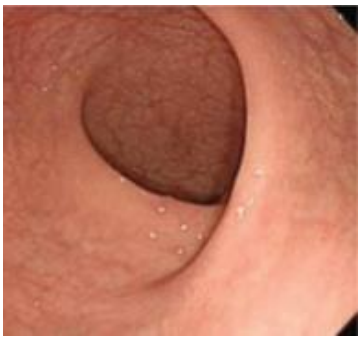


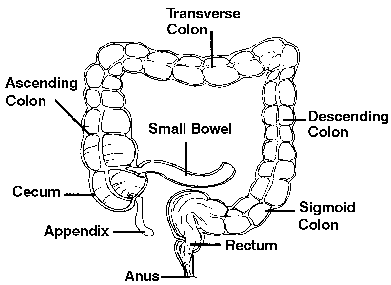




Anatomical Landmark in colon

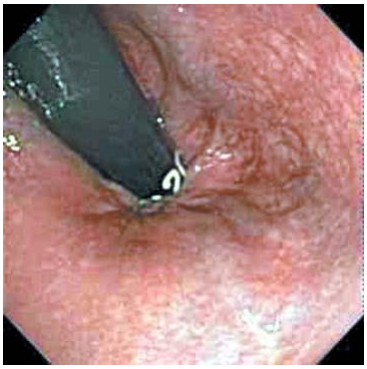
Sigmoid colon

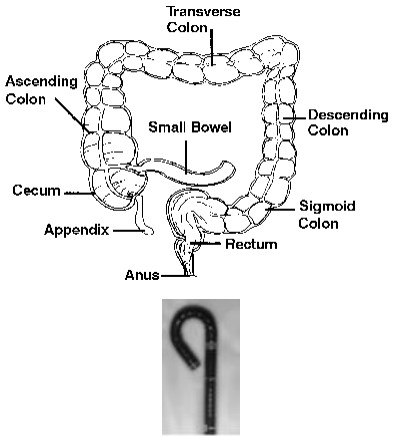




Anatomical Landmark in colon

Rectum





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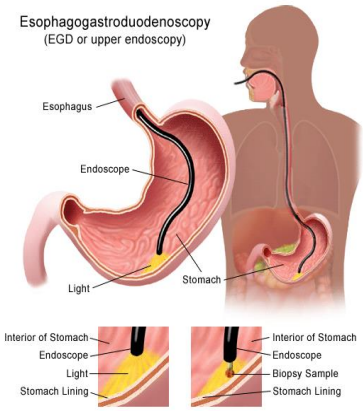
Endoscopic procedure

Upper Endoscopy

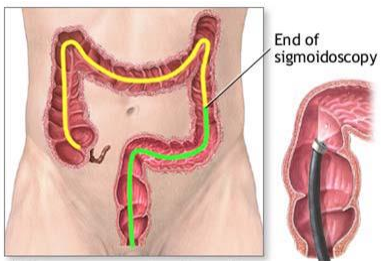
EGD = Esophagogastroduodunoscopy



- Esophagoscopy
  Only view esophagus to LES
- Esophagogastroduodenoscopy
  - Standard procedure
  - Esophagus – stomach – duodenal bulb – 2nd part duodenum
- Push enteroscopy
  - Using pediatric colonoscopy
  - Advance to Jejunum

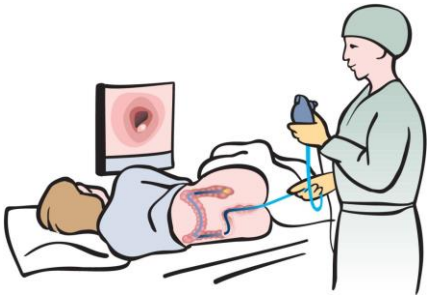
Upper Endoscopy

Flexible Sigmoidoscopy



- Using Flexible sigmoidoscope or Upper endoscope
- Advance to distal to spenic flexure

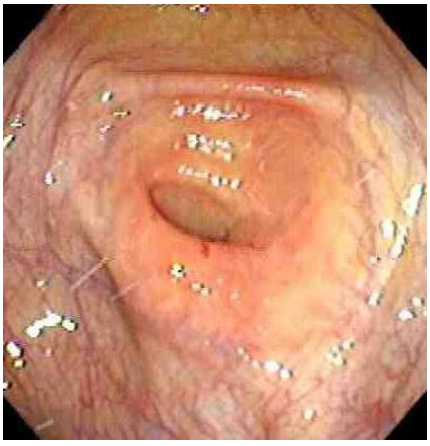
Colonoscopy

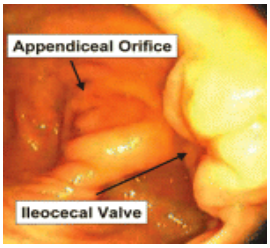


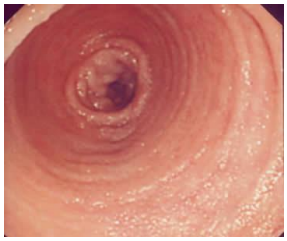
- Using pediatric colonoscope or adult colonoscope
- Advance to proximal to splenic flexure
- Goal :

1. Cecum, identified by appedical orifice and/or IC valve (direct visualization, transillumination, palpation)
2. Terminal Ileum

Goal

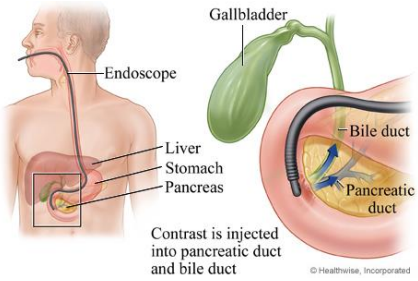


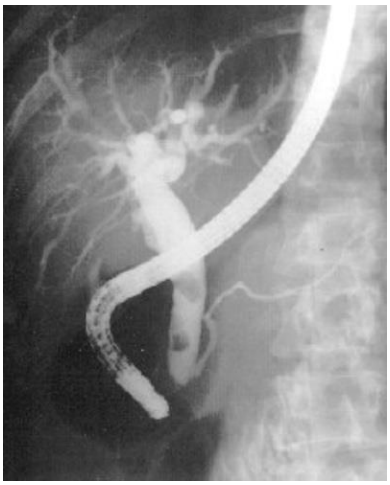




Endoscopic retrograde cholangiopancreatography (ERCP)

- Examination of bile duct and pancreatic duct using a side view endoscope.
- Use Fluoroscopy with ragiograph interpretation



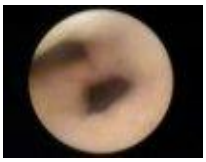


ERCP

- Diagnostic ERCP
  - Biopsy / Brushing cytology
  - Manometry
- Therapeutic ERCP
  - Endoscopic sphincterotomy
  - Removal / Destruction of stones
  - Insertion of stent – Metal vs Plastic
  - Dilation of strictures

Cholangioscopy

- Mother-Daughter scope
- Spyglass by Boston Scientific



Polyp = Benign neoplasm ???

- A polyp is an abnormal growth of tissue projecting from a mucous membrane

Pathologic diagnosis = don't know at the time of procedure

- Malignant : cancer, dysplasia
- Adenomatous :serrated, tubular, villous.
- Hamartomatous/Juvenile
- Hyperplastic
- Inflammatory
- Skin tag, lymphoid aggregate, normal colonic tissue

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Ref : www.pulseinc.com

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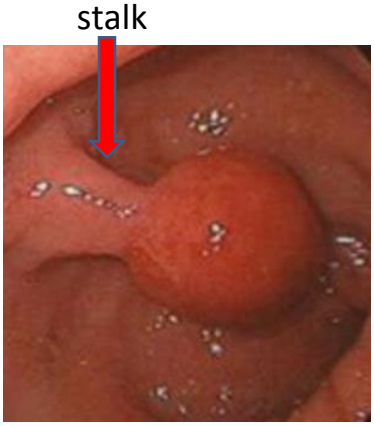
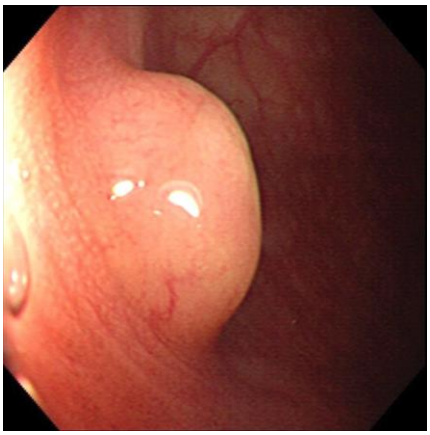
Peduncalated polyp

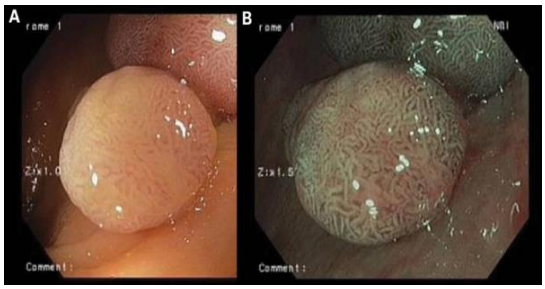


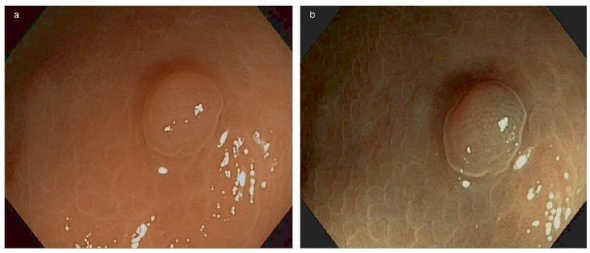
Sessile polyp



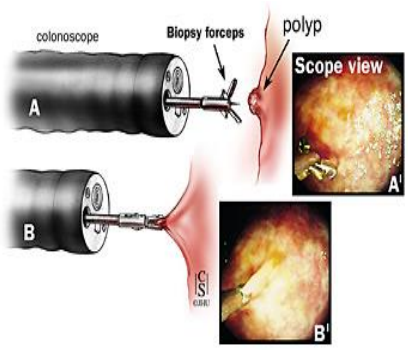
- No stalk

Narrow band imaging

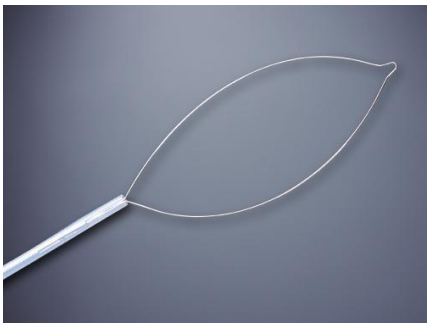


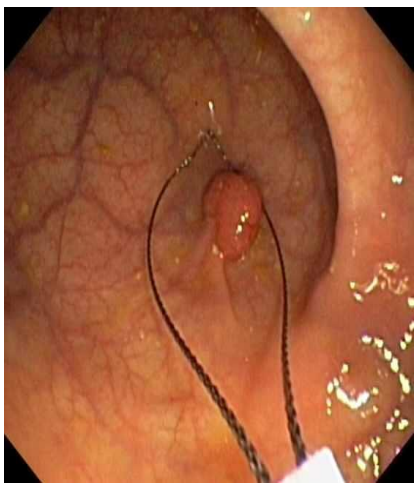


Forcep Biopsy



Snare polypectomy



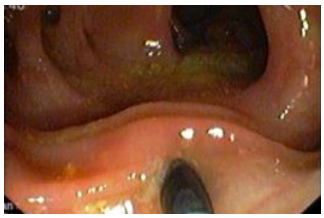
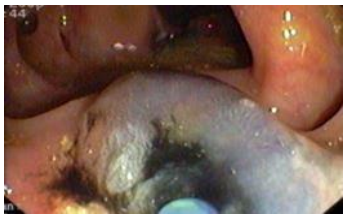
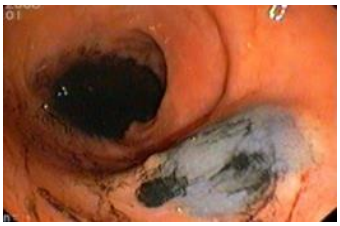
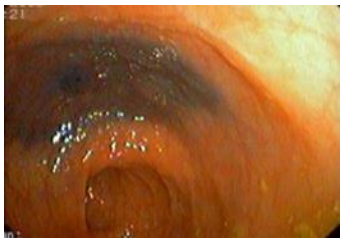


Cauterization

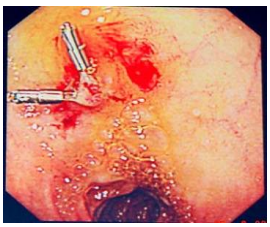
- Burning of part of a body to remove or close off a part of it in a process called cautery
- Hot Forceps
- Hot snare

Endoscopic Injection

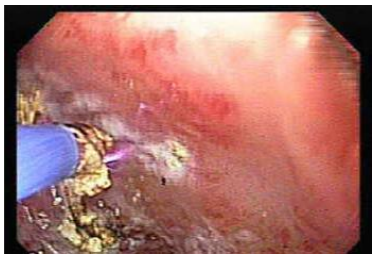
- Sclerosing agent, such as ethanolamine, absolute alcohol, Histoacryl glue (cyanoacrylate)
- Steroid
- Botulinum Toxin
- India Ink for tattoo
- Saline for Lift polypectomy
- epinephrine

Endoscopic hemostasis



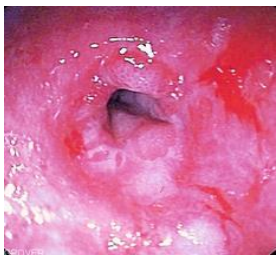
Argon plasma coagulation (APC)

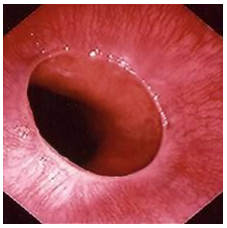


- Use to provide tissue coagulation and hemostasis
- Angiodysplasia, GAVE – gastric antral vascular ectasia,

  bleeding malignant tumors and
  bleeding peptic ulcer

Dilation





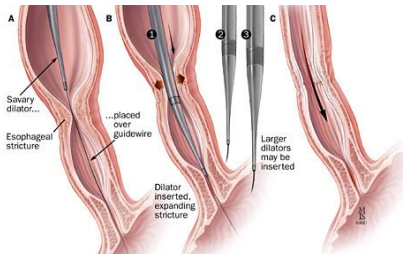
- **Mercury weighted bougies** - Maloney
- **Bougie over guidewire dilators -** Savary-Gilliard*
- **Pneumatic dilatation***
- **Balloon dilatation**

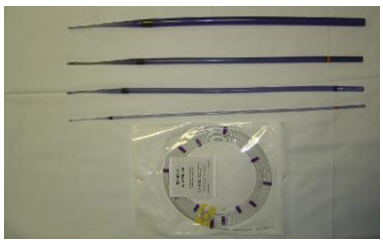
***Floroscopy**

Maloney

- blindly inserted bougies placed into the esophagus by the treating physician or patient.
- They are passed in sequentially increasing sizes to dilate the obstructed area.

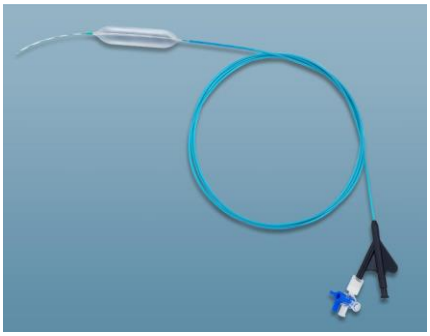
Savary-Gilliard





- Use Guidewire during endoscopy
- Billable for radigraphic interpretation

Balloon Dilatation



Endoscopy report and billing

- Dictation system
- Electronic medical record
  -Provation
  -gMed
  -EndoSoft
  -Endoeasy
  -Mediscope

Report : Key subject areas

Patient demographics and history

Assessment of patient risk and comorbidity

Procedure indication(s) ⬅

Procedure: technical description

Colonoscopic findings

Assessment

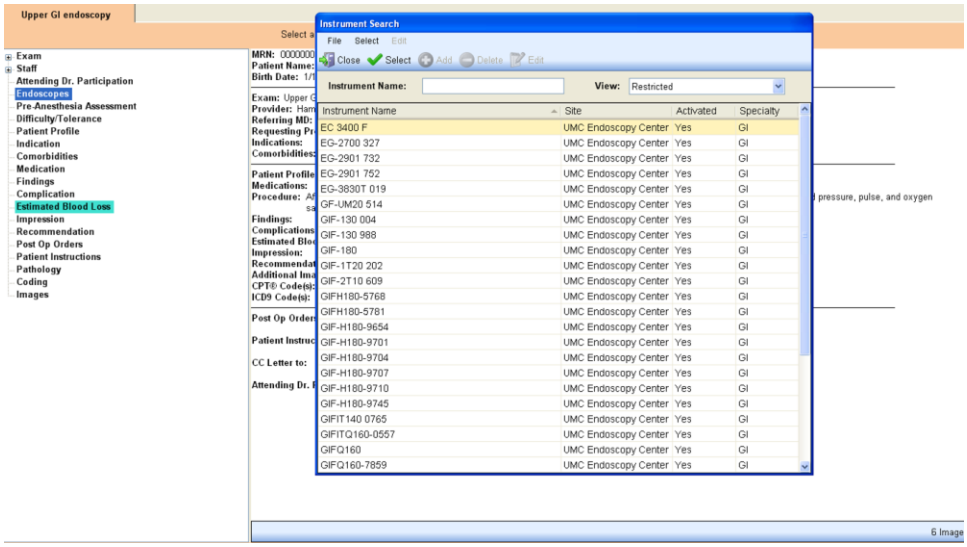
Interventions/unplanned events

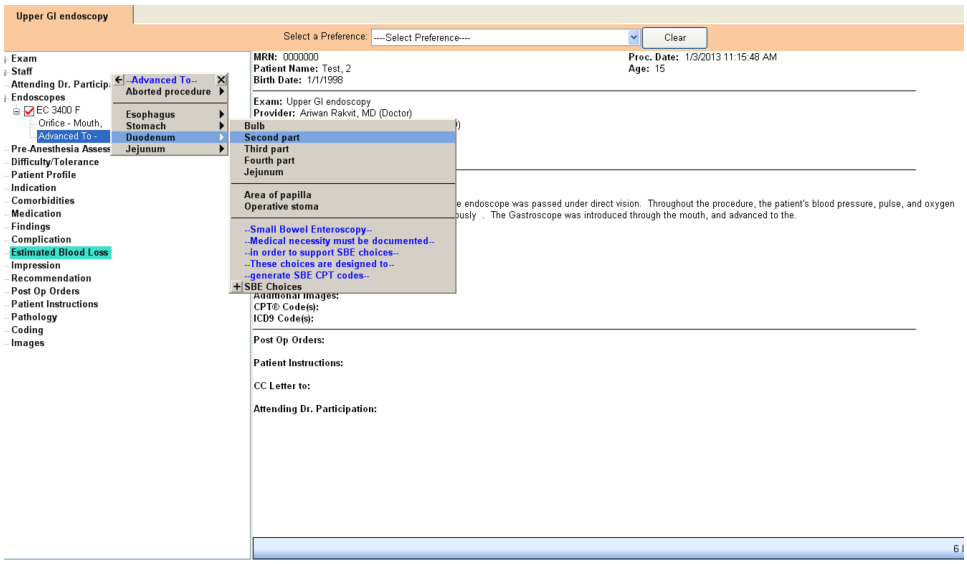
Follow-up plan

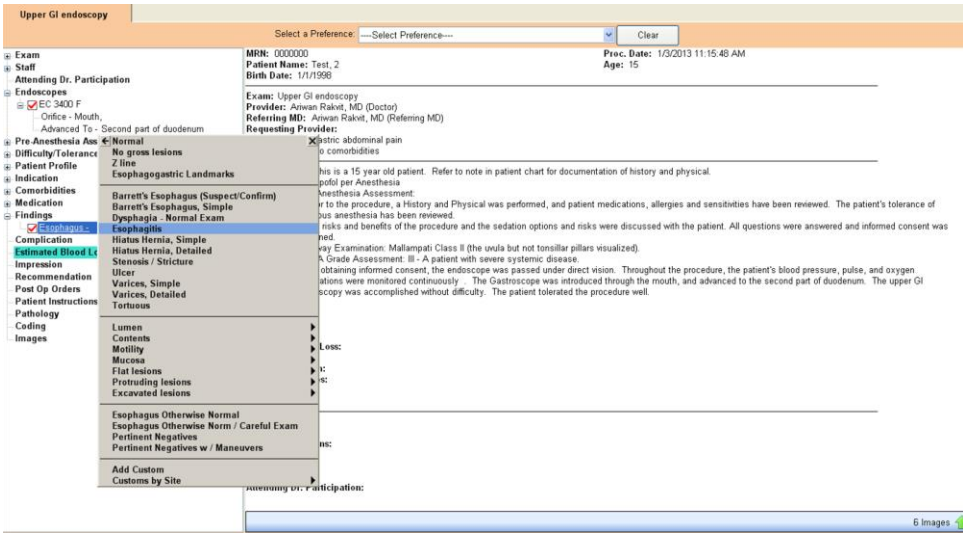
Pathology

Provation MD Gastroenterology

- Develop in 2002
- Widely used in hospital and ambulatory surgical center (ASC)
- Automatic coding system


Upper GI endoscopy
Instrument Search
File Select Edit
Close Select Add Delete Edit
Instrument Name:
View: Restricted
Instrument Name | Site | Activated | Specialty
EC 3400 F | UMC Endoscopy Center | Yes | GI
EG-2700 327 | UMC Endoscopy Center | Yes | GI
EG-2901 732 | UMC Endoscopy Center | Yes | GI
EG-2901 752 | UMC Endoscopy Center | Yes | GI
EG-3830T 019 | UMC Endoscopy Center | Yes | GI
GF-UM20 514 | UMC Endoscopy Center | Yes | GI
GIF-130 004 | UMC Endoscopy Center | Yes | GI
GIF-130 988 | UMC Endoscopy Center | Yes | GI
GIF-180 | UMC Endoscopy Center | Yes | GI
GIF-1T20 202 | UMC Endoscopy Center | Yes | GI
GIF-2T10 609 | UMC Endoscopy Center | Yes | GI
GIFH180-5768 | UMC Endoscopy Center | Yes | GI
GIFH180-5781 | UMC Endoscopy Center | Yes | GI
GIF-H180-9654 | UMC Endoscopy Center | Yes | GI
GIF-H180-9701 | UMC Endoscopy Center | Yes | GI
GIF-H180-9704 | UMC Endoscopy Center | Yes | GI
GIF-H180-9707 | UMC Endoscopy Center | Yes | GI
GIF-H180-9710 | UMC Endoscopy Center | Yes | GI
GIF-H180-9745 | UMC Endoscopy Center | Yes | GI
GIFIT140 0765 | UMC Endoscopy Center | Yes | GI
GIFITQ160-0557 | UMC Endoscopy Center | Yes | GI
GIFQ160 | UMC Endoscopy Center | Yes | GI
GIFQ160-7859 | UMC Endoscopy Center | Yes | GI
Exam
Staff
Attending Dr. Participation
Endoscopes
Pre-Anesthesia Assessment
Difficulty/Tolerance
Patient Profile
Indication
Comorbidities
Medication
Findings
Complication
Estimated Blood Loss
Impression
Recommendation
Post Op Orders
Patient Instructions
Pathology
Coding
Images
pressure, pulse, and oxygen
6 Image


Upper GI endoscopy
Select a Preference: ----Select Preference----
Clear
Exam
Staff
Attending Dr. Particip
Endoscopes
EC 3400 F
Orifice - Mouth
Advanced To--
Pre-Anesthesia Assess
Difficulty/Tolerance
Patient Profile
Indication
Comorbidities
Medication
Findings
Complication
Estimated Blood Loss
Impression
Recommendation
Post Op Orders
Patient Instructions
Pathology
Coding
Images
--Advanced To--
Aborted procedure
Esophagus
Stomach
Duodenum
Jejunum
Bulb
Second part
Third part
Fourth part
Jejunum
Area of papilla
Operative stoma
--Small Bowel Enteroscopy--
--Medical necessity must be documented--
--in order to support SBE choices--
--These choices are designed to--
--generate SBE CPT codes--
SBE Choices
MRN: 0000000
Patient Name: Test, 2
Birth Date: 1/1/1998
Proc. Date: 1/3/2013 11:15:48 AM
Age: 15
Exam: Upper GI endoscopy
Provider: Ariwan Rakvit, MD (Doctor)
e endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen
busly . The Gastroscope was introduced through the mouth, and advanced to the.
Additional Images:
CPT® Code(s):
ICD9 Code(s):
Post Op Orders:
Patient Instructions:
CC Letter to:
Attending Dr. Participation:



Other details

Bowel preparation quality: percent adequate to detect polyps >5 mm

Cecal intubation rate

Rate of photodocumentation of cecal landmarks

Mean colonoscopic withdrawal time in patients without polypectomy or biopsy

Adenoma detection rate in first-time screening examination based on patient's sex

Adverse or unplanned events occurring within 24 h of colonoscopy

Rates of

- Hospitalization
- Bleeding, requiring transfusion
- Bleeding, requiring unplanned endoscopic intervention
- Perforation
- Surgery

Rate of documentation of recommendations for follow-up

GI endoscopy coding guide

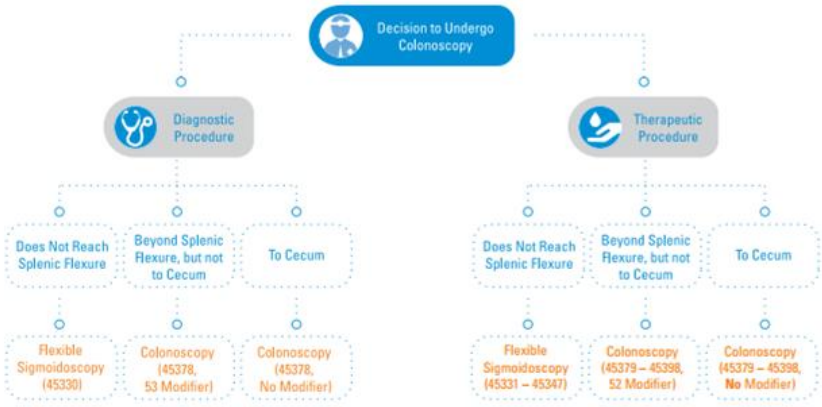
- Current Procedural Terminology (CPT) code set is maintained by the American Medical Association through the CPT Editorial Panel.
- International Classification of Diseases :
  ICD-10

CPT code

- Current Procedural Terminology code is a registered trademark of the American Medical Association.
- The AMA holds the copyright for the CPT coding system.
- Despite the copyrighted nature of the CPT code sets, the use of the code is mandated by almost all health insurance payment and information systems, including the Centers for Medicare and Medicaid Services (CMS) and HIPAA
- As a result, it is necessary for most users of the CPT code to pay license fees for access to the code

CPT 2014 → CPT 2015

- Main change is for colonoscopy



- Average risk screening, by definition, is a service performed on a patient in the absence of signs and symptoms.
- A patient is eligible for screening colonoscopy on or after age 50.
- Some payors allow for screening to begin at age 45 for patients of certain gender and/or ethnic origin.

- Medicare's definition of average risk is
- no personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease, including Crohn's disease and ulcerative colitis
- no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer

- Easiest way is for the physician to mark "average risk for colon cancer screening"
- Do not mention any symptoms : Hematochezia, constipation, abdominal pain, diarrhea, etc.

Abnormal occult blood test **(ICD 10 = R19.5)**

- If a patient has abnormal fecal occult blood test (FOBT), fecal immunochemical test (FIT), or other brand, then colonoscopy is no longer a screening procedure.
- For Medicare is no longer a preventive service = patient is now responsible for the co-pay/deductible for the diagnostic colonoscopy
- For commercial payors, check payor policy.

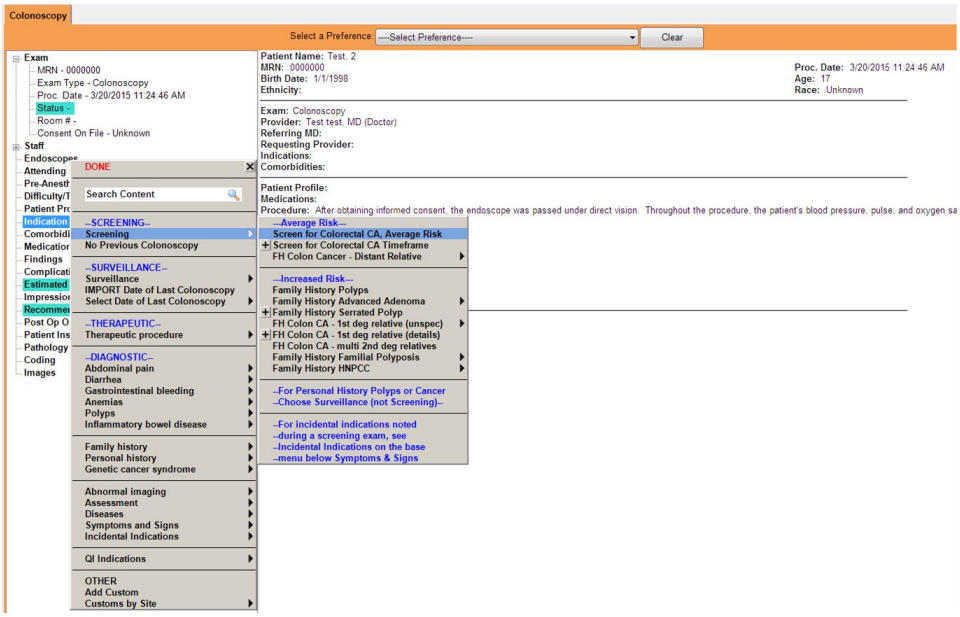
Billing for Screening colonoscopy in an average risk patients

- Medicare: G0121
- Commercial, Medicaid: 45378 with the appropriate ICD-10
  - ICD-10 codes for colorectal cancer screening: Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79

High risk screening/surveillance

- Patients who have
- a personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease OR
- a family history of adenomatous polyps, colorectal cancer, familial adenomatous polyposis or hereditary nonpolyposis colorectal cancer
- Family history as including only first degree relatives (siblings, parents or children).

- Billing for screening/surveillance colonoscopy in a high risk patient:
- Medicare: G0105
- Commercial, Medicaid, Tricare: 45378

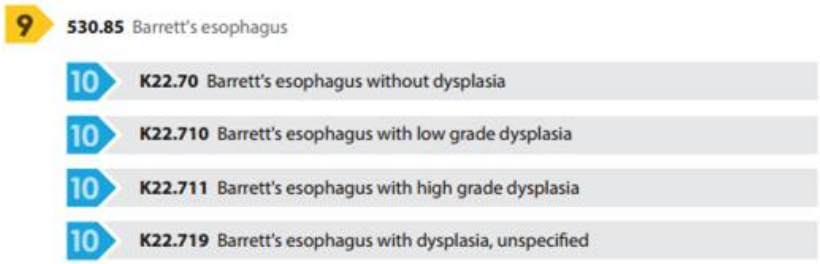


ICD

- The International Classification of Diseases (ICD) is published by the World Health Organization (WHO)
- It is known as a health care classification system that provides codes to classify diseases.
- It is used in several aspect of health care, including reimbursement.

ICD-10

- More details = specific location
- AAPC provides ICD code-9 to ICD code 10 conversion



Ref : www.pulseinc.com

9 **455.0** Internal hemorrhoids without compliction

- 10 **K64.0** 1st degree hemorrhoids
- 10 **K64.1** 2nd degree hemorrhoids
- 10 **K64.2** 3rd degree hemorrhoids
- 10 **K64.3** 4th degree hemorrhoids
- 10 **K64.8** Other hemorrhoids (without mention of degree)
- 10 **K64.9** Unspecified hemorrhoids

9 **556.9** Ulcerative colitis, unspecified

- 10 **K51.90** Ulcerative colitis, unspecified
- 10 **K51.911** Ulcerative colitis, unspecified with rectal bleeding
- 10 **K51.912** Ulcerative colitis, unspecified with intestinal bleeding
- 10 **K51.913** Ulcerative colitis, unspecified with fistula
- 10 **K51.914** Ulcerative colitis, unspecified with abscess
- 10 **K51.918** Ulcerative colitis, unspecified with other complications
- 10 **K51.919** Ulcerative colitis, unspecified with unspecified complications

Re

Anesthesia

- A -33 modifier should be added to the 00810 anesthesia code to include anesthesia for screening colonoscopy.
- For Medicare, add modifier PT to anesthesia code if lesion is found during colonoscopy.

Challenges

- Get familiar with Gastroenterology report / dictation system.
- Good communucation with your gastroenterologist.
  - Lesion is found during a screening colonoscopy
  - Incomplete procedure.
- Multiple endoscopy procedures.

Lesion is found during a screening colonoscopy

- During a screening colonoscopy, polyps or other lesions can be found which are biopsied or removed.
- The procedure is now considered a "surgical colonoscopy", even though the initial indication was screening.
- ?? patient's financial responsibility

- For commercial payors, add modifier 33 to the claim
- It informs the payor that the intent of the colonoscopy was a preventive service.
- Then billed with screening as the principal diagnosis and the finding as the secondary diagnosis
- Many commercial payors will continue to pay preventive benefits

- For Medicare, add modifier PT to the claim.
- It informs Medicare that the intent of the colonoscopy was a preventive service.
- Modifier PT waives the patient's deductible
- But the patient is now responsible for the 20% co-pay.

Incomplete procedure : modifiers 52 and 53

- Upper endoscopy vs colonoscopy :
- EGD Not examined because significant situations preclude such exam (e.g., significant gastric retention precludes safe exam of duodenum, or blood in stomach)
- If repeat examination is not planned = append modifier 52
- If repeat examination is planned = modifier 53

Example 1

- EGD is performed and a tube is placed into the stomach.
- The duodenum is not examined and there is no plan to perform repeat EGD to examine the duodenum.
- Report procedure with modifier 52

Example 2

- EGD is performed for evaluation of GI bleeding
- the stomach is full of blood and the duodenum is not examined.
- Plan to control bleeding, lavage stomach and repeat upper endoscopy.
- Report procedure with modifier 53.

Colonoscopy : modifiers 52 and 53

- If it is diagnostic or screening endoscopic procedure and unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances,
- Report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation. (ie : inadequate bowel preparation quality, mass)

- If a therapeutic colonoscopy (44389-44407, 45379, 45380, 45381, 45382, 45384, 45388,45398) is performed and does not reach the cecum or colon-small intestine anastomosis,
- Report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.

Example 1

- 55-year-old male, asymptomatic, undergoing screening colonoscopy.
- The scope was advanced to the cecum, but prep is incomplete with poor visibility.
- He returned for repeat colonoscopy after repeat prep. no lesions are biopsied or removed

- The incomplete first attempt report is 45378 with Modifier 53
- The second attempt report is G0121

Example 2

- 57-year-old male undergoing high risk screening due to personal history of transverse colon cancer.
- The scope was advanced to the ascending colon, but prep is incomplete with poor visibility
- He returned for repeat colonoscopy after repeat prep. no lesions are biopsied or removed

- The incomplete first attempt report is 45378 with Modifier 53
- The second attempt report is G0105 (high risk)

Example 3

- 72-year-old female undergoing screening colonoscopy.
- Obstructing mass found in the transverse colon, which prevented examination of the right colon. Biopsies were taken.

- Report 45380 with Modifier 52 (for incomplete)

+

- either modifier PT (if a Medicare beneficiary) or 33 (if a commercial, Medicaid, Tricare patient) → indicates the procedure was intended to be screening; but once a biopsy was performed it became therapeutic

Multiple endoscopy procedures

- Be specific as to how the biopsy/polypectomy was performed.

  The phrase, “multiple polypectomies" does not give enough information to submit a claim.

- LOCATION, LOCATION, LOCATION.

  In order to get paid for the different techniques in different sites within the intestine, the location of the lesion is important.

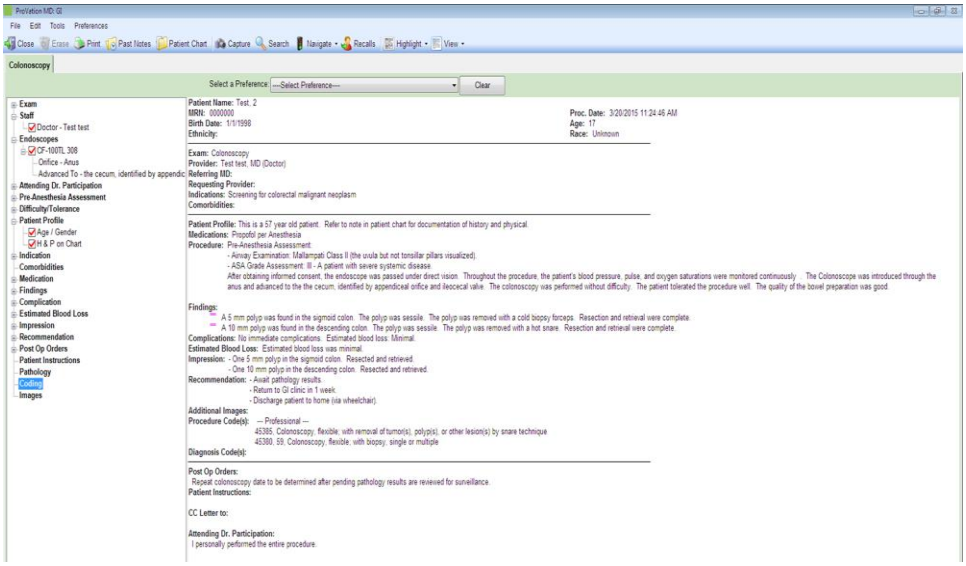
  - So, go back to the beginning of the presentation : anatomy

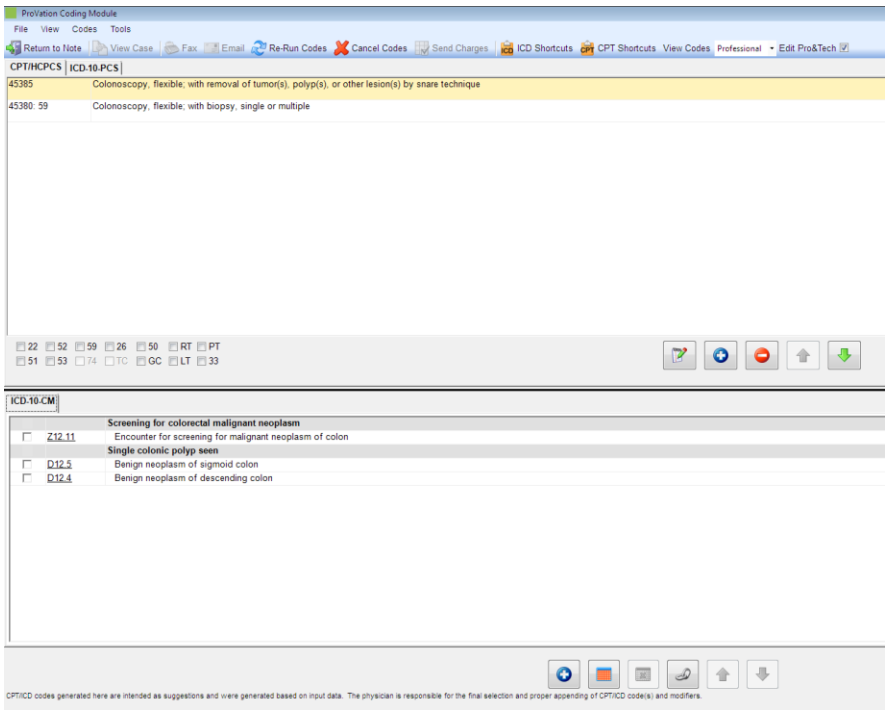
- D12.0 Benign neoplasm of cecum
- D12.1 Benign neoplasm of appendix
- D12.2 Benign neoplasm of ascending colon
- D12.3 Benign neoplasm of transverse colon
- D12.4 Benign neoplasm of descending colon
- D12.5 Benign neoplasm of sigmoid colon
- D12.6 Benign neoplasm of colon, (polyposis)
- D12.7 Benign neoplasm of rectosigmoid junction
- D12.8 Benign neoplasm of rectum
- D12.9 Benign neoplasm of anus and anal canal

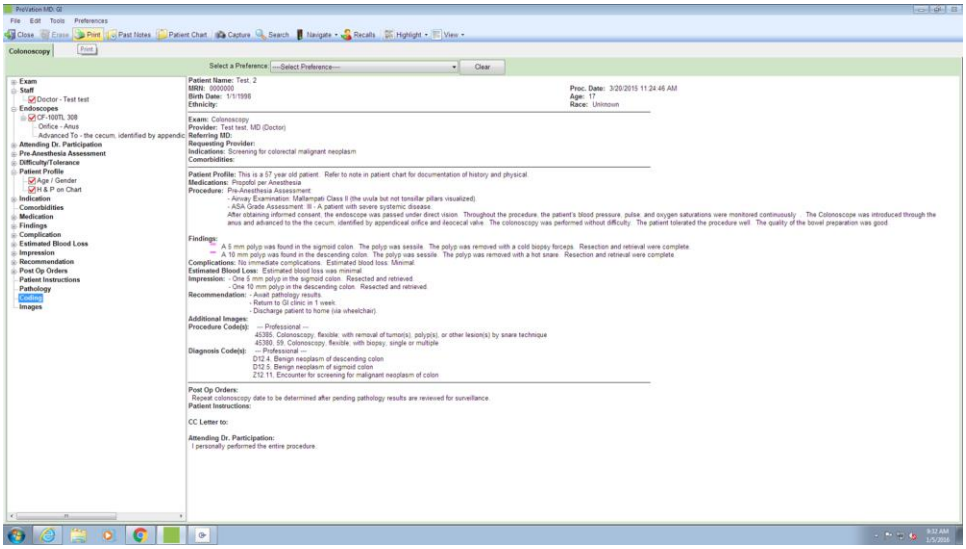
Anemia

- Anemia unspecified (D64.9) is not covered by most Medicare payers for colonoscopy and/or upper GI endoscopy.
- Be specific : payable code
- D50.9 Iron deficiency anemia, unspecified
- D50.0 Chronic blood loss anemia

Sample report







Summary

- Understand the report system at your practice.
- Good communication and feedback with your physician. **If you have questions, don't make a decision by yourself**
- Double check "automatic coding system" by the electronic medical record.
- Location, Indication and Detail of each procedures

- Questions

- CEU code

Office visit for screening colonoscopy

- For Medicare, unless the patient has symptoms or a chronic condition/disease that has to be managed by the GI provider, an E/M visit prior to the colonoscopy is not covered and will be denied with no patient responsibility.

- For private payors, it will depend whether preventive visits are covered.
- Remember that when billing new patient (99201–99205) or existing patient (99212–99215) E/M codes, there should be a chief complaint.
- Each payor may have individual policies; for instance, Anthem BC/BS policy is to bill this as a preventive visit 99381– 99397.