**Gastrointestinal Endoscopy Coding**

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**GI Anatomy**

- Liver
- Duodenum
- Ascending colon
- Terminal ileum
- Cecum
- Stomach
- Transverse colon
- Descending colon
- Small intestine
- Sigmoid colon
- Rectum

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**Accessing the GI Tract**

Through - Mouth, anus, stoma

Endoscope can be- Rigid
- Esophagoscope
- Sigmoidoscope
- Anoscope

or flexible fiber optic scopes

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**Endoscopy**

Direct visualization of GI system by means of lighted, flexible tube.

Endoscopy Codes: Include the scope and any procedure performed through the scope.

Can be done as Diagnostic- Abdominal pain, inflammation, obstruction.

GI Bleed, due to a specific disease, repair an organ.

As a screening.
Procedure Note

Documentation is the key to proper coding!

1. What was intended to be performed?
2. Diagnostic, therapeutic, screening?
3. Was anything removed?
4. Techniques used to remove tissue?
5. Any complications?
6. When will the patient have this procedure again?
7. Key words- injection, excision, dilation, ligation, biopsy, forceps, etc.

The Pancreas is approximately 6 inches long, in the upper abdomen, adjacent to the small intestine.

The pancreas has three parts:

The head of the pancreas sits in the curve of the duodenum at the level of the 2nd and 3rd vertebrae.

The common bile duct descends diagonally across the back of the pancreatic head.

The body of the pancreas lies horizontal and the tail turns slightly upward as it reaches toward the edge of the spleen.
**The Gallbladder** is a pear-shaped sac that lies on the inferior surface of the liver.

**The gallbladder has three regions:**

- The **fundus**, a distal bulbous portion, which can project below the inferior edge of the liver.
- The **body** which contacts both the colon and the duodenum.
- The **neck** connects the fundus and the body to the cystic duct.

The large green structure is a very distended gall bladder that needs to be removed.

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**The Colon’s main functions is the storage and concentration of fecal material. Bacteria live in the large intestine to help with food degradation. Important fat-soluble vitamins, such as Vitamin K, are derived from bacterial activity and absorbed in the colon.**

The **ascending colon** extends from the cecum to the right colic flexure. The **transverse colon** is attached to the posterior abdominal wall. The **descending colon** extends from the splenic flexure to the sigmoid colon. The **sigmoid colon** is S-shaped and extends to the **rectum** which stores feces prior to defecation.
The liver's main job is to filter the blood coming from the digestive tract, before passing it to the rest of the body.

The Pancreas is both an endocrine gland producing hormones including insulin as well as an exocrine gland secreting pancreatic juice containing digestive enzymes that assist the absorption of nutrients.
Colorectal cancer screening test; converted to diagnostic test or other procedure.

**Guidelines** - This modifier is effective for dates of service on or after January 1, 2011.

Submit this modifier with the appropriate CPT code for colonoscopy, flexible Sigmoidoscopy, or barium enema when the service is initiated as a colorectal cancer screening service but becomes a diagnostic service.

This modifier is valid for CPT codes 10000-69999.

The Part B deductible and coinsurance do not apply to these services.

**Medicare CRC Screening: Diagnostic Modifier-PT**

In the final rule, CMS created for Medicare a new Healthcare Common Procedure Coding System (HCPCS) modifier-PT (CRC screening test, converted to diagnostic test or other procedure) to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible Sigmoidoscopy HCPCS code, or as a result of the barium enema when the screening test becomes a diagnostic service.
**Modifier -22**

CPT describes modifier 22 as Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code.

Documentation must support:
1. The substantial additional work
2. The reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

**Modifiers –TC and -26**

Technical Component refers to certain procedures that are a combination of a physician component and a technical component. Using modifier TC identifies the technical component.

Modifier 26 and TC are considered payment modifiers and must be reported in the first modifier field.
- Do not report a procedure code with both modifiers 26 and TC
- Interpretation only is modifier -26. Used when MD is reviewing and diagnosing.
- Technical component procedures are institutional and should not be billed separately by the physician.
Modifier -51

Modifier 51 is used to indicate that multiple procedures (other than E/M) were performed at the same session by the same provider.

Use modifier 51 on the second and subsequent operative procedures when the procedures are ranked in RVU order.

Some carriers do not like this modifier, check with your carriers before submitting!

Modifier -52

Use Modifier -52:
When procedure is partially reduced or eliminated at the physician’s Discretion.
Remember some carriers will not recognize it.

Don't Use Modifier -52:
When reporting an elective cancellation of a procedure before taken into The area where anesthesia induction is done.
When reporting discontinued procedures.
**Modifier -53**

Discontinued Procedure:
Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure.

Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

*Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 and HCPCS codes G0105 and G0121 only.*

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**Modifier -59**

For Distinct Procedural Service

1. When using this modifier, Medical Documentation is vital and essential to support medical necessity. This must be well-documented on the patient's medical record.
2. This modifier may represent a different body site or organ system.
3. This modifier may represent a separate lesion.
4. This modifier may represent a different area of injury.
5. This modifier may represent a different procedure.
6. This modifier may represent a separate incision or excision.
7. This modifier represents a distinct and independent procedure/surgery/encounter from other services performed.
Incomplete Colonoscopy

Inability to extend scope beyond/proximal to the splenic flexure. Applies to both screenings and diagnostic colonoscopies.

CPT STATES:  
“For an incomplete colonoscopy with full preparation for a colonoscopy, use colonoscopy code with modifier -52”

MEDICARE STATES:  
Use modifier -53

G Codes

Colorectal Cancer Screenings for a Medicare patient:

G0105 High Risk patient  
A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp (a type of polyp that could become cancerous)  
A family history of familial adenomatous polyposis (this involves multiple adenomatous polyps, often in the hundreds, and carries a very high risk of colon cancer)  
A family history of hereditary nonpolyposis colorectal cancer (a type of colorectal cancer that runs in families and tends to cause cancer at a relatively young age - under 45 years)  
A personal history of adenomatous polyps  
A personal history of colorectal cancer  
A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis

G0121 Non High Risk patient
Let’s Go Into The Procedure Room

Here’s your Colonoscope

Patient Number One

“Gladys”

72 year old female
First colonoscopy
Insurance Medicare
Not high risk

Prep was good
Normal colonoscopy
Return 10 years

ICD: V76.51
CPT: G0121
**Her Sister needed one too!**

“Penelope”

78 years old
History of polyps
Surveillance
Insurance Medicare

Prep poor
Scope to cecum
Repeat 1 year

ICD: V67.09, V12.72
CPT: 45378-53

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**AGA Rationale**

- Given Medicare’s time restriction of two years between two high risk screenings and 10 years between two average risk procedures, if a screening is repeated in one year, it will be denied by Medicare as "not medically necessary." If the physician wants to repeat the procedure within the restricted time, the first procedure should be billed with a 53 modifier, even though the scope advanced beyond the splenic flexure.
Patient Number Three

"Sam"

82 years old. Very healthy
First colonoscopy
Prep good
Polyp found & removed via
cold biopsy forceps, add’l biopsies obtained
Insurance Medicare

ICD: V76.51
CPT: 45380 -PT

AGA Rationale

- If a patient presents for a screening colonoscopy and a polyp
  is removed during the procedure, what is the correct way to
  identify the ICD-9 diagnoses codes?

For all payors, if the procedure was initiated as a screening,
the screening diagnosis is primary and the polyp is secondary.
In the line with the polypectomy procedure code, in Box 24E
(the diagnostic pointer box) enter a "2" linking the procedure
with the polyp. In this way the patient will receive the
insurance benefits associated with screening procedures and
the service will be paid correctly.
Colonoscopy VS. Sigmoidoscopy

Colonoscopy examines the entire length of the colon; sigmoidoscopy examines only the lower third.

Sigmoidoscopy

Proctosigmoidoscopy- examines the rectum and sigmoid colon
CPT 45300-45327

Sigmoidoscopy- examines rectum, sigmoid colon, may include a portion of the descending colon.
CPT 45330-45345
Yes BOTOX!

But for Hemorrhoids!

In some instances, Botox is used as a sclerosing solution.

The use of Botox (botulism toxin) injections weaken the anal sphincter and allow healing.

CPT: 46500

Patient Number Four

“Rueben”

Rueben did not complete the prep as directed. The endoscope could not advance beyond the sigmoid.

97 yrs old
First colonoscopy
Symptom- Melena
Insurance- Medicare

ICD: 578.1
CPT: 45378-53
AGA Rationale

• If a patient is scheduled for a screening colonoscopy and because of a poor prep the scope cannot be advanced beyond the splenic flexure, do I code the procedure as a flexible Sigmoidoscopy?

No. Per Medicare guidelines, the procedure should be codes as a colonoscopy with a 53 modifier which will pay a partial fee and allow you to repeat the procedure within the restricted time period and get full payment for the second procedure. Even if the scope was advanced beyond the splenic flexure but the visualization was poor and the physician wants to repeat the procedure within the restricted time period, add the 53 modifier.

Patient Number Five

Charlie – 55 yrs
First colonoscopy
Symptom- diarrhea
Self Pay
Through the Scope

You notice a “mass”

Irrigate to get a closer look

Raise with Injection

Directed submucosal injection to lift. Bleeding occurred when we began injecting.

Hemoclip applied to control bleeding.
Let’s use a SNARE

Cold Snare used as a lasso

Snare is adjusted at base and removed through endoscope

“Location difficult. Extra 70 mins spent”
Code Charlie’s Case

- ICD: 787.91
- ICD: 235.2
- CPT: 45385-22

AGA Rationale

- **If I remove a polyp and the site bleeds and I inject epinephrine or place an endoclip to control the bleeding, can I bill for the control of bleed in addition to the polypectomy?**

  No. If you cause the bleed, the control of bleed is not separately billable. However, if the patient was bleeding at one location and a polyp is removed from another location, you can bill the control of bleed with a 25 modifier.

- **Is there a separate code for the placement of an endoclip?**

  There is not a separate code. If the endoclip is used to control a bleed, the code is control of bleed (see above). If the endoclip is used to close a fissure or other purpose, use an unlisted procedure code.

- **Can I use a modifier -22?**

  If the procedure took significantly longer than usual, you can append the modifier 22. You must submit the procedure report as well as a statement indicating why the procedure took so much longer and how much longer it took.
Thanks for the Questions!

- If a patient is referred to our office for a screening colonoscopy and the patient is on Coumadin, can we bill for the visit?

Yes. If the patient requires some intervention on the part of the gastroenterologist prior to the procedure, you can bill a New Patient or Established Patient visit, depending on whether the patient has received any face-to-face service by anyone in your office within the last three years.

- Can I bill multiple codes for the removal of multiple polyps using the same method of removal?

No. One method, one code. If so many polyps were removed that the procedure took significantly longer than usual, you can append the modifier 22. You must submit the procedure report as well as a statement indicating why the procedure took so much longer and how much longer it took.
• If I use multiple methods to remove multiple polyps, can I bill for each method?

Yes, as long as each method was used on a different polyp. To get paid for multiple methods, you must append the modifier 59 to the codes that are bundled into one another according to the National Correct Coding Initiative (NCCI) edits. For example, one polyp is removed using a snare, another is removed using cold biopsy forceps. The 59 goes on the biopsy because that is the code that is bundled under NCCI.

• The physician inserted a decompression tube during a colonoscopy. How do I code for the tube placement?

Though the CPT definition of a colonoscopy states, “with or without decompression,” it does not include the placement of the decompression tube. As there is no code for the placement of the tube, it is advised that you add an “unlisted procedure” code to the code for the colonoscopy. An “unlisted procedure” is any CPT code ending in "99" for which there is no specific definition and no assigned relative value units (RVUs). When using an “unlisted procedure” code, the claim must be accompanied by a detailed description of the procedure as well as an estimate of the performance time. The billing fee can be selected by comparing the procedure with one that has an assigned fee.
**Medicare**

- **What are the Medicare’s time restrictions for a screening colonoscopy?**
  
  For average risk patients, a screening colonoscopy is limited to once every 10 years. For high risk patients (personal history of colon cancer or polyps, family history of colon cancer), a screening colonoscopy can be performed once every 24 months.

- **If a patient is average risk and had a screening colonoscopy 2 years ago but now presents with symptoms that would justify a diagnostic colonoscopy, will Medicare pay for the second procedure?**
  
  Yes. The time restrictions only apply between two screenings (patient has no symptoms).

- **What are the new screening benefits for Medicare patients?**
  
  Effective January 1, 2011, if a patient presents for a screening colonoscopy or flexible sigmoidoscopy (no GI symptoms), Medicare will waive both the deductible and coinsurance when billing the G codes for the screening.

- **What happens if, during the course of a screening, we do a biopsy or polypectomy?**
  
  Medicare will still waive the deductible, but the patient will be responsible for the coinsurance. Append the PT modifier to the CPT code.
Let’s Do More Procedures!

Patient Number Six

“Mildred”

EGD Performed
Esophageal Reflux confirmed
Random Biopsies taken

ICD: 530.81
CPT: 43239

76 yrs old
Symptom: Reflux (GERD)
Insurance- Medicare
Patient Number Seven

"Heloise"

68 Years Old
Sent to us by PCP
Swallowed something??
Insurance-Medicare

Coin found in esophagus and safely retrieved during EGD

ICD: 935.1
CPT: 43247

Patient Number Eight

"Tex"

80 yrs. Old
Alcoholic Cirrhosis of Liver
Esophageal Varies (bleeding)
EGD
Insurance- Medicare

Rubber Band Ligation
Multiple (up to six) rings can be deployed from the device onto the varices by means of release strings without retraction of the endoscope.

ICD: 571.2
ICD: 456.0
CPT: 43244
**Peg Tubes**

The percutaneous endoscopic gastrostomy (PEG) is an effective and easy method to facilitate continuous feeding in all patients unable to swallow. These are mostly patients disabled by stroke and cerebral insufficiency or by stomach-, esophagus- and ENT- cancer.

ICD: 269.8, 263.9, 996.59
CPT: 43246 (placement)
CPT: 43761 (repositioning)

**Capsule Endoscopies**

A diagnostic procedure involving swallowing a capsule containing a tiny camera. It takes pictures as it glides through the small intestine and is then excreted from the body. It can help diagnose polyps, cancer, or causes of bleeding and anemia.
**Coding Tips**

1. Check Carriers Coverage
2. Have EGD/Colonoscopy done prior.
3. Use ICD V45.89 as second diagnosis.
4. The physician can only bill for the professional component (26 modifier) of a diagnostic test performed in the hospital. The hospital would have to bill for the professional component.

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**Bravo Probe System is a pH monitoring system**

- **A.** With this system, pH data are transmitted to a data recorder by a capsule attached to the esophageal mucosa.
- **B.** The capsule is a self-contained pH probe, transmitter, and battery.
- **C.** The capsule is placed using an introducer that can be passed transnasally or transorally.
- **D.** After several days, the capsule falls off and is passed out the gastrointestinal tract. There is no need to recover the capsule because the pH data are transmitted to the data recorder.

CPT: 91035
For Interpretation Use CPT: 91035-26
**Biliary System**

Endoscopic retrograde cholangiopancreatography, or ERCP, is a study of the ducts that drain the liver and pancreas. Ducts are drainage routes into the bowel. The ones that drain the liver and gallbladder are called bile or biliary ducts. The one that drains the pancreas is called the pancreatic duct. The bile and pancreatic ducts join together just before they drain into the upper bowel, about 3 inches from the stomach. The drainage opening is called the papilla. The papilla is surrounded by a circular muscle, called the sphincter of Oddi.

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**ERCP (Endoscopic Retrograde Cholangiopancreatography)**

Enables the physician to diagnose problems in the liver, gallbladder, bile ducts, and pancreas. ERCP is used primarily to diagnose and treat conditions of the bile ducts, including gallstones, inflammatory strictures (scars), leaks (from trauma and surgery), and cancer. ERCP combines the use of x rays and an endoscope, which is a long, flexible, lighted tube. Through the endoscope, the physician can see the inside of the stomach and duodenum, and inject dyes into the ducts in the biliary tree and pancreas so they can be seen on x rays.
**What is a therapeutic ERCP?**

Diagnostic ERCP is when X-ray contrast dye is injected into the bile duct, the pancreatic duct, or both. This contrast dye is squirted through a small tube called a catheter that fits through the ERCP endoscope. X-rays are taken during ERCP to get pictures of these ducts. That is called diagnostic ERCP. However, most ERCPs are actually done for treatment and not just picture taking. When an ERCP is done to allow treatment, it is called therapeutic ERCP.

**Patient Number Nine**

“Mary”

In the common bile duct.

ICD: 576.2  
CPT: 43263 or 43264

77 yrs. Old  
Bile duct obstruction  
Presents for ERCP  
No Insurance
**Patient Number Ten**

“Clyde”

31 yrs. Old
Bile duct obstruction
Presents for ERCP
No Insurance

In the distal part of the biliary duct is the inflated extraction balloon.
ICD: 576.2
CPT: 43271

**Gallstones**

Endoscopic retrograde cholangiopancreatography is performed with removal of stone(s) from the biliary and/or pancreatic ducts. An endoscope is passed through the esophagus, stomach, and into the duodenum to the point where the pancreatic duct and the common bile duct meet, (the Ampulla of Vater), at the major duodenal papilla. A smaller catheter is placed through the scope, the ampulla of Vater is cannulated, and contrast dye is injected into the ducts. The common bile duct, biliary tract, gallbladder, and pancreas are visualized on x-rays, taken as soon as the dye is injected. A balloon catheter is inserted and swept down past the biliary or pancreatic duct calculus (stone). The balloon is inflated and the stone is extracted by slow withdrawal of the balloon catheter. Alternatively, a basket extraction can be performed. The basket extraction device is inserted, the calculus is trapped within the device, and the basket is then slowly withdrawn. One or more calculi may be removed during this procedure. If nothing is found use the 52 modifier.

CPT: 43264
**Stent Placement**

Stents are placed into the bile or pancreatic ducts to bypass strictures, or narrowed parts of the duct. These narrowed areas of the bile or pancreatic duct are due to scar tissue or tumors that cause blockage of normal duct drainage. There are two types of stents that are commonly used. The first is made of plastic and looks like a small straw. A plastic stent can be pushed through the ERCP scope into a blocked duct to allow normal drainage. The second type of stent is made of metal wires that looks like the cross wires of a fence. The metal stent is flexible and springs open to a larger diameter than plastic stents. Both plastic and metal stents tend to clog up after several months and you may require another ERCP to place a new stent. Metal stents are permanent while plastic stents are easily removed at a repeat procedure. Your doctor will choose the best type of stent for your problem.

**Patient Number Eleven**

“Dan”

Plastic stent inserted to the pancreatic duct for treat- of chronic pain induced by Acute Pancreatitis.

CPT: 43268
**ERCP Stone Removal with Sphincterotomy**

The above pictures are from an ERCP performed for a patient with a bile duct obstructed by a gallstone. The picture on the left shows the bulging major papilla. Next, a catheter is guided into the bile duct, and a sphincterotomy is made to enlarge the opening of the bile duct. The final picture shows the gallstone falling out of the bile duct after the sphincterotomy.

CPT: 43264, 43262

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**Stent placement in multiple ducts**

Obstructions of the bile duct and pancreatic duct is the placement of plastic stents into the ducts. Here, the physician has placed two stents into the bile duct, and one stent into the pancreatic duct to treat a stenosis (or narrowing).

CPT: 43268
43268-59
43269-59
A Closer Look

Two long plastic stents are implanted into the right and left hepatic duct.

Congratulations!

Sorry, it's all in fun!
**You coded- but have you ever seen?**

**Barium Swallow**

- **Polyp on a Stalk**

**Crohn's disease**

A chronic inflammatory bowel disease affecting the colon, ileum and other parts of the digestive tract. It is characterized by skip lesions (diseased areas separated by normal bowel segments).

**ulcerative colitis**

Inflammatory disease of the colon manifested by mucosal inflammation with ulceration.
Crohn’s Disease In Colonoscopy

Divertica
Barrett’s
Gastritis
References

American Gastrological Association  http://www.gastro.org/
American Medical Association    http://www.ama-assn.org/
World Gasterology Organization    http://www.worldgastroenterology.org/
Yale School of Medicine            http://www.Yale.edu

Questions

Thank you for attending this session!