

Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
AAPC

The following document includes the most frequently asked coding and billing questions received by the AGA Coding and Billing Answer Line. Answers are provided by the AGA's staff of certified and experienced coders. This information is meant to help gastroenterologists and their staff understand the ever-changing coding and billing rules in order to maximize revenue and avoid audit exposure. For additional details about the AGA Coding and Billing Answer Line, please visit <http://www.gastro.org/practice/practice-management/coding-billing-answer-line>.

1. **What code do I use for Medicare patients the first time I see them in the hospital?**
2. **Now that we can't use the Consultation codes for Medicare patients, what code do we use for the first visit to our office?**
3. **What code do we bill when we are asked to see a Medicare patient in the emergency room?**
4. **Can we still use the Consultation codes for private payors?**
5. **What if a Medicare patient was seen within the last three years but is referred to our office for another problem?**
6. **How do I bill for a patient seen in our office prior to a screening colonoscopy with no GI symptoms and who is otherwise healthy?**
7. **If a patient is referred to our office for a screening colonoscopy and the patient is on Coumadin, can we bill for the visit?**
8. **If a nurse practitioner or physician assistant sees a new patient in the office and then discusses the patient with a physician, can we bill the visit under the physician?**
9. **If the physician removes a polyp using cold biopsy forceps, do we bill a biopsy, snare polypectomy or an ablation?**
10. **We are getting denials for capsule endoscopies performed in the hospital that we are billing globally because we own the equipment and pay for the capsule. Why?**
11. **Can I bill multiple codes for the removal of multiple polyps using the same method of removal?**
12. **If I use multiple methods to remove multiple polyps, can I bill for each method?**
13. **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?**
14. **Is there a separate code for the placement of an endoclip?**
15. **The physician inserted a decompression tube during a colonoscopy. How do I code for the tube placement?**
16. **If, during an ERCP, a stent is placed in both the biliary and pancreatic ducts, can I bill for both stents?**
17. **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?**

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18. 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?
19. When our physician places a Bravo capsule and then does the interpretation and report, what date of service do we use?
20. Can we bill separately for the radiology component of an EUS or other endoscopy if performed in an ASC/AEC?
21. What are the Medicare's time restrictions for a screening colonoscopy?
22. 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?
23. If a patient presents for a screening colonoscopy and the scope was advanced to the cecum but visualization was poor and the physician wants to repeat the procedure in one year, how do we code the first procedure?
24. If the physician planned to do an EGD but, due to an obstruction, could not advance the scope to the duodenum, should I bill an esophagoscopy?
25. What are the new screening benefits for Medicare patients?
26. What happens if, during the course of a screening, we do a biopsy or polypectomy?
27. Medicare now requires a documented History and Physical Exam (H&P) prior to procedures performed in our ASC. Can we bill an E/M code for the H&P?
28. If a patient presents to our office with symptoms, such as difficulty swallowing, and after taking a history and examining the patient the physician decides that the patient needs an immediate procedure, can we get paid for both the procedure and the visit on the same day?
29. When placing the Bravo capsule endoscopically, can we bill for the EGD and the capsule?
30. If we do a procedure that is not defined by a CPT/HCPCS code can we bill a code that is similar?
31. Can you please explain the difference between CPT code 44382 and 44386?
32. We are having trouble getting paid for the new hospital observation codes. Every time we bill a 99225 it gets denied for the following reason: "A discrepancy exists between the procedure code and the place of service reported. Please resubmit the claim with the correct place of service or procedure code." We are billing the place of service as outpatient since the patient was in observation status. Do you have any additional information on this code?
33. My doctor recently inserted a gastrostomy tube and then advanced it into the jejunum. Is there a code that describes what he did?
34. When there is residual food and/or debris in the stomach and my doctor either aspirates or irrigates to remove this, can a code for removal of foreign body be billed?
35. What is the code when an endoclip is used to close a gastrogastic fistula per endoscopic placement?

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
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36. What is the difference between modifiers PT and 33?
37. What is the correct way to code for a double balloon enteroscopy?
38. My physician performed a scope and dictated that chromoendoscopy was done. How do I code for this?
39. Our GI physicians often give capsules to patients prior to their x-rays. Our charge is \$42.50. Many of the insurance carriers do not pay for these as they state it's included in the global fee, and very few payors will pay for them. Can we bill the patient for the Sitzmark(s) if the payor will not cover them?
40. I was recently looking at the relative value units (RVUs) assigned to CPT codes. Why are there two different RVUs for outpatient visits and not for inpatient visits?
41. When doing a hemorrhoidal banding and flexible sigmoidoscopy during the same session, can both be billed?
42. We have a patient who has esophageal cancer. In conjunction with his radiation oncologist, the doctor has done several EGDs with brachytherapy catheter placement into the distal esophagus. What code can be used for this procedure?
43. Are three measures required to do Physician Quality Reporting Initiative (PQRI) reporting to Medicare? Does it matter which three the practice chooses?
44. What would I code for endoscopic retrograde cholangiopancreatography (ERCP) with injection?
45. The physician dictated he used a 3rd Eye Retroscope. How do I code this?
46. When should I use modifier 33?
47. My physician would like to give a discount to friends and relatives. Is this legal?
48. What is the correct way to bill for total parenteral nutrition (TPN) management of a hospitalized patient?
49. Should I require all of my patients to sign an Advance Beneficiary Notice of Non-Coverage (ABN)?
50. How should a sphincterotomy be billed if the physician treats more than one sphincter?
51. My physician performed an endoscopy on a patient in the morning and later that same evening had to repeat the endoscopy due to bleeding. Can I bill for the second procedure?
52. When a patient comes to the office to have a G-tube changed, what diagnosis code should I use?
53. My physician performed an ERCP and changed two stents. How do I code this?
54. Have the rules changed for billing a capsule endoscopy?
55. My physician wants to start using radiofrequency to treat internal hemorrhoids. Are there special guidelines for this type of treatment?
56. A cardiac arrhythmia was found when the monitors were applied to a patient at our

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practice's ambulatory surgery center. The procedure was cancelled before any drugs had been administered. What would be the best modifier to use?

57. **Question: When should I use the code G0105?**
58. **My physician stated that he is going to perform TIF procedures. What is it and how do I code it?**
59. **We have many patients that require an interpreter to accompany them for office appointments at our expense. Even though we confirm the appointment with the patient the day before, often the patient is a "no show." We then have to pay for an interpreter that was not needed. Are we allowed to bill the patient or the insurance company for the cost of the interpreter?**
60. **Our physician requests patients to bring in a frozen stool specimen to test for *H pylori* bacteria. The specimen is prepared in the office and is sent to the lab for analysis. Can we bill for stool specimen preparation, or does the lab bill the entire service? If yes, what CPT code would we bill?**
61. **My physician sometimes dictates bipolar current and sometimes uses the term hot biopsy. What is the difference?**
62. **My physician performed a drainage of a pancreatic pseudocyst. Can I bill for the ultrasound and fluoroscopy with this?**
63. **I know our practice will eventually have an audit by RAC (Recovery Audit Contractors). What areas are they focusing on for GI practices?**
64. **The practice that I work for is joining a hospital system. I have been told I will have to work with the 3 Day Rule. What is it exactly?**
65. **My physician performed a "three dimensional motility test" of the esophagus. Is there a specific code for this?**
66. **Can I bill 43263 twice if my physician performed an ERCP and obtained pressure measurement readings in both the pancreatic and common bile ducts?**
67. **What diagnosis code is best to use for a patient who has had a previous cecostomy?**
68. **When my physician removes a biliary stent endoscopically and not by ERCP technique, is the correct code 43247?**
69. **What is Optical Endomicroscopy?**
70. **My physician wants to start using a capsule to measure GI transit and pressures measurements from the stomach through the colon. How does this work? Is there a special code to use for billing?**
71. **Is there a new code for fecal bacteriotherapy?**
72. **What is a GIST and how do I code it?**
73. **My physician managed care and performed an upper GI endoscopy on a patient in the critical**

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care unit. What are the guidelines for billing this?

74. Is there is a specific screening code when a flexible sigmoidoscopy is performed? If so, would it be a different code if the patient has a history of colon cancer and colon polyps?
75. My physician wants to bill for the IV start and supplies for infusions. Is that allowable?
76. What is included in time-based billing in the hospital setting?
77. What is a Split/Shared visit?
78. What is the correct code for billing High Resolution Esophageal Pressure Topography (HREPT)?
79. Our office received a consult for one of our physicians. His nurse practitioner saw the patient, discussed the case with the physician, and then dictated the history, exam, and treatment plan. Can this be billed "incident to"?
80. My physician wants an office visit to examine a donor before a fecal transplant. What code should I use for the pre-donation visit?
81. Our practice owns a building that houses both the physician offices and our Ambulatory Surgery Center (ASC). Is it correct to bill place of service (POS) 11 for the physician charge and POS 24 for the facility charge?
82. Can we bill a separate evaluation/management (E/M) visit with a 25 modifier when our physicians examine the patient and dictate a history and physical immediately before performing a procedure at a surgery center?
83. My physician performed a biopsy of the small intestine using a side viewing scope. Is there a specific code for this scope?
84. My physician rarely provides critical care services. When we do bill for critical care, we have trouble receiving reimbursement. Are there special guidelines that we should be following?
85. We are trying to pre-certify a patient for a CT enterography. What are the correct CPT code(s)?
86. When my physician performs an endoscopic drainage of a pancreatic pseudo cyst, are there any additional charges I can bill or am I limited to just 43240?
87. Is a patient with private insurance liable for cost sharing when a screening colonoscopy becomes diagnostic?
88. My physician interpreted a Bravo on an outpatient with Medicare at the hospital. How should this be coded?
89. Our practice is starting to use the Fibroscan. What CPT code can we use to submit a claim?
90. My physician is using an injectable bulking agent to treat fecal incontinence. What are the CPT and diagnosis codes that I can use?
91. My physician is planning on using a vibrant capsule. What is it and how do I bill for it?
92. What is the CMS "Two Midnight Rule"?

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93. Is it true that colonoscopy cost sharing was eliminated for privately insured patients?
94. My physician states that the submucosal injection code, 43236, has been unbundled. Is this true and how do I correctly bill?
95. At what age does Medicare stop covering average risk screening colonoscopies?
96. My physician performed an esophagogastroduodenoscopy (EGD) but was unable to examine the duodenum. What is the correct modifier in this circumstance?
97. Is an esophagoscopy limited strictly to the esophagus?
98. Can I bill a dilatation of a ductal stricture in addition to a stone removal during an ERCP (endoscopic retrograde cholangio-pancreatography)?
99. My physician performed an Endoscopic Retrograde Cholangiopancreatography (ERCP) but was unable to cannulate the pancreatic duct. What is the correct way to code this?
100. My doctor removed a biliary stent using a snare, but did not do an Endoscopic Retrograde Cholangiopancreatography (ERCP). How should this procedure be billed?
101. My physician stated that a patient had a Dieulafoy's lesion of the stomach. What is that and how would I code the condition?
102. A physician in our practice plans on performing an EGD on a patient that has had a previous Billroth II. Are there special codes that would apply to this situation?
103. My physician stated that we should be reporting Category II codes for a screening colonoscopy. Can you please clarify what this means?
104. I am considering adding a nutritional/weight loss clinic to my practice. Is a dietitian required for this service? Are there billing guidelines?
105. Does the three year rule for new versus established patients apply in a hospital setting?
106. What should be documented on the capsule endoscopy report and/or any other diagnostic studies interpreted by the GI physicians/providers?
107. If a physician sees an observation patient covered by Medicare for the first time but the physician was not the admitting physician what CPT codes range do we use?
108. Can CPT codes 43242 and 43259 be reported on the same claim?
109. My doctor performed an upper EUS with FNA. FNA was done of the celiac lymph node, gastro-hepatic lymph node, and pyloric lymph node. I will use code 43242 but since the FNA was done of multiple sites can I bill additionally: 43242-59, 43242-59 and 43239-59?
110. While a colonoscopy was performed a decompression tube was inserted over a wire. Based on my research I think that we should only be billing 45378; however, I want to make sure that I am using the most appropriate code.
111. I received a denial for code 43255 citing it is incidental to the 43270 which was paid. I can't find any documentation on the 43270 that shows these codes together are mutually exclusive.

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112. A patient was seen for a colonoscopy. During the procedure the scope was unable to advance past the sigmoid due to an obstruction/mass. Biopsy was taken. In this instance should we bill for a limited colonoscopy with biopsy or sigmoidoscopy with biopsy?
113. We continue to have ongoing discussions (i.e., disagreements) regarding the proper use of the V76.51 code. If we have a patient with a family history or polyps or colon cancer, can we use the V76.51 and V18.51 together with the V76.51 being primary? And if the patient returns 5 years later, without any findings on the first procedure, for a follow-up colonoscopy for the same reason can we use the V76.51 again?
114. If a patient has ulcerative colitis and is asymptomatic but the physician is scheduling colonoscopies every 2–5 years for the UC, how should this be coded, specifically for commercial payers? Is this considered a true “screening” that should be paid under screening benefits?
115. If a patient had a stent exchanged in the Common Bile Duct, is it possible to also bill for the removal of the Pancreatic stent, considering different ducts?
116. What code do you use for a Upper gastrointestinal endoscopy that turns in to a enteroscopy (the enteroscope was advanced well into the jejunum).
117. We have some confusion as to the verbiage in the report that we should be looking for to identify an endoscopic mucosal resection (EMR). We would like some clarification/ understanding of the CPT 45390, colo w/EMR. Is it the same as a (45385) polypectomy with saline injection to lift (45381)? If we see this verbiage are we to assume that this is in fact an EMR and should be billing 45390?
118. Should we be billing Medicare claims with modifiers, XE, XS, XP, or XU in place of modifier 59?
119. One of our technologists believes that it is appropriate to bill twice for both 78264 and the radiopharmaceutical when performing the gastric emptying study with liquid and solid food; it is my understanding that the standard for the test is to perform with both liquid and solid food, and therefore should only be billed once for the entire study (performed on the same day). Can you please clarify?
120. Can a provider bill for a consult on a patient they have seen for a procedure and deem it necessary for the patient to be admitted? For example, a physician performs an EGD on a patient for anemia and a GI bleed is found. The physician finds that the patient is unstable after the procedure has concluded and requests that the patient be admitted by the hospitalist service. Can the GI physician then consult on this patient that he is requesting be admitted?
121. What is the CPT code for a flexible sigmoidoscopy with endoscopic mucosal resection?
122. My doctor performed an EGD with biopsy. He went past the duodenum and to the jejunal loop. What CPT code do I use for that?

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123. I have a procedure scheduled as ERCP. The esophagus and stomach are normal. There was some difficulty getting into the duodenum as the pylorus was eccentrically placed due to the pancreatic fluid collection or pancreatic necrosis. However, the duodenum was cannulated with the ERCP scope and duodenum findings revealed a small opening where the ampulla is supposed to be, draining creamish liquid. This opening was entered using a wire that crossed the spine and then dye was injected. Injection of dye did not delineate the pancreatic duct suggesting no intact pancreatic duct remaining. Is this reported with 43260?

124. I have been told that a 45383 (ablation of a polyp) was going to be coded with 45388 in 2015 but now that is not working either. They were supposed to do away with 45383 - deleted code. How should this procedure be reported?

New! **125. Can we still use modifiers 25, 59, TC, 26 for claims with dates of service after 10/1/15?**

New! **126. We know that if a patient has a history of polyps, and they return to have a repeat surveillance colonoscopy years later, that it is not a screening colonoscopy. It is billed as a preventative service, with the personal history of colon polyps as the dx. But if a polyp is hyperplastic, instead of adenomatous, would it still be a surveillance colonoscopy or would the provider be able to bill a screening colonoscopy? Also, if the reason for the procedure in less than 10 years is due to a patient's family history of colon cancer (and the patient had small benign hyperplastic polyps), can one add the Z12.11 screening code to the history code?**

1. What code do I use for Medicare patients the first time I see them in the hospital?

You use the Initial Hospital Visit codes (99221-99223). If you are the admitting physician add the AI modifier to the code.

2. Now that we can't use the Consultation codes for Medicare patients, what code do we use for the first visit to our office?

If no one in your office of the same specialty has provided any face-to-face service to the patient in the last three years, you bill a New Patient visit (99201-99205). If the patient has been seen within the last three years, you bill an Established Patient visit (99211-99215).

3. What code do we bill when we are asked to see a Medicare patient in the emergency room?

99281-99285.

4. Can we still use the Consultation codes for private payors?

Yes, unless you are notified otherwise by the payor.

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5. What if a Medicare patient was seen within the last three years but is referred to our office for another problem?

You can only bill for an Established Patient visit (99211-99215).

6. How do I bill for a patient seen in our office prior to a screening colonoscopy with no GI symptoms and who is otherwise healthy?

The visit prior to a screening colonoscopy for a healthy patient is not billable.

7. 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.

8. If a nurse practitioner or physician assistant sees a new patient in the office and then discusses the patient with a physician, can we bill the visit under the physician?

No. New Patient visits must be billed under the nurse practitioner/physician assistants' NPI/provider number unless the payor tells you otherwise in writing.

9. If the physician removes a polyp using cold biopsy forceps, do we bill a biopsy, snare polypectomy or an ablation?

You bill a biopsy.

10. We are getting denials for capsule endoscopies performed in the hospital that we are billing globally because we own the equipment and pay for the capsule. Why?

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 technical component.

11. 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.

12. If I use multiple methods to remove multiple polyps, can I bill for each method?

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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.

13. *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 it 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.

14. *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.

15. *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.

16. *If, during an ERCP, a stent is placed in both the biliary and pancreatic ducts, can I bill for both stents?*

Yes. As the definition of the of 43267 states, “tube” as singular, if more than one tube is placed, each tube can be billed separately with the 59 modifier placed after the code for each tube other than the first.

17. *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

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
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period, add the 53 modifier.

18. 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.

19. When our physician places a Bravo capsule and then does the interpretation and report, what date of service do we use?

The date of interpretation/date of report should be the date used for billing the Bravo studies.

20. Can we bill separately for the radiology component of an EUS or other endoscopy if performed in an ASC/AEC?

Medicare bundles the ultrasound and fluoroscopy into the endoscopy and therefore they are not separately billable. Other radiology services performed in an ASC are not billable.

21. 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.

22. 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).

23. If a patient presents for a screening colonoscopy and the scope was advanced to the cecum but visualization was poor and the physician wants to repeat the procedure in one year, how do we code the first procedure?

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.

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- 24. *If the physician planned to do an EGD but, due to an obstruction, could not advance the scope to the duodenum, should I bill an esophagoscopy?***
No. Bill the EGD with a 52 modifier indicating a reduced service.
- 25. *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.
- 26. *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.
- 27. *Medicare now requires a documented History and Physical Exam (H&P) prior to procedures performed in our ASC. Can we bill an E/M code for the H&P?***
No. The H&P is considered part of the procedure and is not separately billable.
- 28. *If a patient presents to our office with symptoms, such as difficulty swallowing, and after taking a history and examining the patient the physician decides that the patient needs an immediate procedure, can we get paid for both the procedure and the visit on the same day?***
Yes. As long as you have a documented E/M service during which the decision was made to do the procedure, you can bill both the procedure and the visit with a 25 modifier on the visit. You will receive full payment for both.
- 29. *When placing the Bravo capsule endoscopically, can we bill for the EGD and the capsule?***
If the sole purpose of the EGD is to place the capsule, the EGD is not billable. You bill only for the capsule.
- 30. *If we do a procedure that is not defined by a CPT/HCPCS code can we bill a code that is similar?***
No. You must meet the definition of a code in order to bill it. When there is no code use an unlisted code in that section and send with documentation.
- 31. *Can you please explain the difference between CPT code 44382 and 44386?***
44386 describes evaluation of a small intestinal pouch which usually involves an ileal-anal anastomosis or j-pouch creation. This is usually accessed through an anal approach, but can also be accessed through an abdominal approach into a pouch. The patient usually has had all intestine removed for ulcerative

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colitis, Hirschsprung's disease, trauma, etc. 44382 involves evaluation of the intestinal tract through an ileostomy. There is no pouch access when using this code. Usually this is a temporary ileostomy, but it can also be permanent.

- 32. We are having trouble getting paid for the new hospital observation codes. Every time we bill a 99225 it gets denied for the following reason: "A discrepancy exists between the procedure code and the place of service reported. Please resubmit the claim with the correct place of service or procedure code." We are billing the place of service as outpatient since the patient was in observation status. Do you have any additional information on this code?**

The new subsequent observation care codes have been a little problematic. There are differences between the carriers as to how they should be billed. The CPT book indicates that any provider seeing the patient on subsequent days can bill these codes. CMS indicates that only the admitting provider can bill these codes and those that don't admit can only bill established patient codes 99211-99215 for the subsequent observation care days. The reason for the denial sounds like there is a discrepancy as to the place of service. Double check to make sure that the patient wasn't actually admitted to inpatient even though they were initially admitted to observation status.

- 33. My doctor recently inserted a gastrostomy tube and then advanced it into the jejunum. Is there a code that describes what he did?**

Actually, there are two codes that describe what he did. First, he established the gastrostomy endoscopically (43246) and then he was able to advance a separate attached tube through the gastric outlet into the jejunum for feeding. This is done primarily to prevent aspiration pneumonia. The code for this procedure would be 44373 (endoscopic conversion of PEG to PEJ). Both codes can be billed without any modifiers.

- 34. When there is residual food and/or debris in the stomach and my doctor either aspirates or irrigates to remove this, can a code for removal of foreign body be billed?**

Usually, this code is used to remove something that either is obstructing or will be obstructing the lumen of the GI tract. Normal removal or irrigation of debris, stool, etc., is considered part of the endoscopic procedure and not separately billable.

- 35. What is the code when an endoclip is used to close a gastrogastic fistula per endoscopic placement?**

43235 can be billed for the endoscopy but unfortunately, there is no code that describes endoscopy with gastric fistula closure, so you are stuck with 43999 (unlisted procedure code, stomach).

- 36. What is the difference between modifiers PT and 33?**

These are two new modifiers for 2011. PT is Medicare specific only and when utilized on a surgical

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endoscopy, the deductible is waived but the patient is still responsible for the co-pay that is the patient's responsibility. Example: 45385-PT with diagnosis of V76.51 and 211.3.

Modifier 33 is not specific to colonoscopies since it is used to indicate a preventive service. You might want to use this on a commercial claim that started as preventive and converted to diagnostic/surgical procedures. However, not all payers recognize this modifier since it was only released in January, 2011.

37. What is the correct way to code for a double balloon enteroscopy?

A double balloon enteroscopy (DBE) (push and pull) investigates the small bowel when X-rays, barium follow through, CT or MRI scans show abnormalities. For an antegrade approach, use the enteroscopy including ileum codes: 44376 series. For a retrograde approach, use colonoscopy codes plus unlisted procedure code of 44799.

38. My physician performed a scope and dictated that chromoendoscopy was done. How do I code for this?

Chromoendoscopy involves the topical application of stains or pigments to improve tissue localization or diagnosis during endoscopy. No CPT code exists for this procedure. Since it is considered non-invasive, carriers are considering this to be incidental to the procedure.

39. Our GI physicians often give capsules to patients prior to their x-rays. Our charge is \$42.50. Many of the insurance carriers do not pay for these as they state it's included in the global fee, and very few payors will pay for them. Can we bill the patient for the Sitzmark(s) if the payor will not cover them?

This study is done to evaluate the transit of the intestinal tract. The patient swallows the capsule which contains 24 small rings. Five days later, the patient will have an x-ray done to see if any rings remain in the large intestine. The capsule should be provided by the facility that will be performing the x-ray. However, should you provide the patient with the capsule, whether or not you can bill the patient for the non-covered service depends on the carrier policy.

40. I was recently looking at the relative value units (RVUs) assigned to CPT codes. Why are there two different RVUs for outpatient visits and not for inpatient visits?

RVUs are comprised of three things: location costs, work value and malpractice. These RVUs are released once a year, the last being November 29, 2010. Some procedures which are considered facility only procedures will only have one total RVU assigned. Others procedures, including visits that can be performed in either the office or outpatient/inpatient facilities, will have two different values, with the facility RVU being a lower value since the visit is being performed in a site other than the office where the physician doesn't incur overhead expenses.

41. When doing a hemorrhoidal banding and flexible sigmoidoscopy during the same session, can both

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be billed?

As per CCI edits, 46221 (hemorrhoidal banding) does include 45330 (sigmoidoscopy) if the scope is done only for banding and not for diagnostic purposes. If done for diagnostic purposes, such as to rule out any other bleeding source proximal to the anal area, then it can be separately billed but would require a 59 modifier. The diagnosis code should indicate why the sigmoidoscopy was performed separate from the hemorrhoid treatment.

- 42. *We have a patient who has esophageal cancer. In conjunction with his radiation oncologist, the doctor has done several EGDs with brachytherapy catheter placement into the distal esophagus. What code can be used for this procedure?***

Unfortunately, there is no CPT code or HCPCS code that describes brachytherapy catheter placement; however, the code 43241 does describe tube and/or catheter placement, just not a specific device. Don't forget to use the comment field and enter "brachytherapy catheters."

- 43. *Are three measures required to do Physician Quality Reporting Initiative (PQRI) reporting to Medicare? Does it matter which three the practice chooses?***

PQRI, now known as Physician Quality Reporting Systems (PQRS), does recommend that at least three measures be chosen by the practices for quality reporting in order to be eligible for the 1% incentive bonus. The choice is for a 6 month or 12 month bonus. At this juncture, it is almost too late to be eligible for the bonus, but will be good practice for the year starting on January 1, 2012. Go to www.cms.gov/PQRS for lists of the full measures, along with instructions. Here are some recommended choices for GI practices: Measures 83–90, 128, and 320.

- 44. *What would I code for endoscopic retrograde cholangiopancreatography (ERCP) with injection?***

ERCP is done using a side angle scope and fluoroscopy since direct visualization of the biliary tract is not able to be done like standard endoscopy. Contrast has to be injected in order for the biliary tract to be visualized; therefore the injection is already included into any ERCP code. If ERCP was completed without surgical technique and/or cholangioscopy, you would only bill 43260.

- 45. *The physician dictated he used a 3rd Eye Retroscope. How do I code this?***

It is an imaging device that allows a continuous retrograde view of the colon. You would bill 45378 plus the unlimited procedure code 44799.

- 46. *When should I use modifier 33?***

This modifier went into effect January 1, 2011 to better facilitate claim processing for preventative services. It should be used when the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventative Services Task Force A or B rating or other services

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identified in preventative services mandates (legislative or regulatory). By using modifier 33, you are indicating that the preventative or screening service that you provided should not be subject to deductible, co-pay, or co-insurance.

This preventative care indicator is only for commercial screenings or screenings converted to surgical colonoscopies. Do not use this modifier on medicare screening colonoscopies.

47. *My physician would like to give a discount to friends and relatives. Is this legal?*

As per Stark, CMS and HIPAA, there are only three legitimate reasons for discounts:

- Insurance contract adjustments
- Hardship adjustments (proven by review of financial statements)
- Inability to collect adjustments (usually a fair effort of at least three attempts before determining if it is economically feasible to pursue)

48. *What is the correct way to bill for total parenteral nutrition (TPN) management of a hospitalized patient?*

There is no specific code for TPN management. You can only bill a hospital visit based on the documentation contained in the progress note.

49. *Should I require all of my patients to sign an Advance Beneficiary Notice of Non-Coverage (ABN)?*

No. ABNs are used for Medicare patients and should not be used for commercial patients. Since 1972, providers have been required to notify Medicare beneficiaries when the outpatient service may not be covered by Medicare. This written notice informs the Medicare beneficiary that Medicare may deny some or all of the charge because of medical necessity or the frequency of the service. An ABN must be signed at the time of scheduling a procedure. Check the CMS website for new forms that became mandatory on January 1, 2012.

50. *How should a sphincterotomy be billed if the physician treats more than one sphincter?*

The code for endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy describes the procedure where the sphincter of Oddi is incised to allow flow of bile. Occasionally the sphincter controlling the pancreatic duct may also be incised. If both sphincters are incised, both can be billed. The second code would require a 59 modifier. Comments should be used for each procedure indicating location.

51. *My physician performed an endoscopy on a patient in the morning and later that same evening had to repeat the endoscopy due to bleeding. Can I bill for the second procedure?*

A procedure code for endoscopic control of bleeding may be reported with a 78 modifier, indicating that

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this service represents a return to the operating room for a related procedure during the post-op period.

52. When a patient comes to the office to have a G-tube changed, what diagnosis code should I use?

Depending on the reason for the tube change, possible diagnosis include:

- 536.41 Infection of gastrostomy
- 536.42 Mechanical complication of gastrostomy
- 536.49 Other gastrostomy complications
- V55.1 Attention to gastrostomy

If an office visit is also done that day due to management of feedings and reviewing lab tests, then an office visit can also be billed with the 25 modifier. The diagnosis should not be G-tube management, but rather the reason for the visit, such as a failure to thrive, malnutrition, feeding difficulties, etc.

53. My physician performed an ERCP and changed two stents. How do I code this?

43269 describes ERCP with removal of foreign body and/ or change of tube or stent. This code only indicates one tube or stent. If more than one tube or stent is changed, each can be reported with the appropriate modifier-59. Comments should be used for each procedure indicating location.

54. Have the rules changed for billing a capsule endoscopy?

As of April 1, 2012, a capsule endoscopy should be billed on the date of interpretation (it is no longer billed on the date the data is downloaded).

55. My physician wants to start using radiofrequency to treat internal hemorrhoids. Are there special guidelines for this type of treatment?

46930 describes internal hemorrhoids destroyed with a thermal approach such as radiofrequency. A 90 day global surgical package applies to this code. Some payors have instituted restrictions for treatment, such as a maximum of one per 90 day period and 2 treatments per year.

56. A cardiac arrhythmia was found when the monitors were applied to a patient at our practice's ambulatory surgery center. The procedure was cancelled before any drugs had been administered. What would be the best modifier to use?

Modifier 73 indicates that the patient was in the procedure room but the procedure was not performed prior to anesthesia services. THIS IS FOR FACILITY USE ONLY AND NOT FOR USE ON THE PROVIDER'S CLAIM. The facility will bill the intended procedure. The diagnosis will still be the indication and also the diagnosis of the arrhythmia.

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57. Question: When should I use the code G0105?

G0105 indicates a colorectal cancer screening on an individual at high risk. This code was initially to be used for Medicare patients but is now recognized by most commercial carriers. High-risk individuals meet one or more of the following criteria:

- A close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp
- A family history of familial adenomatous polyposis
- A family history of hereditary nonpolyposis colorectal cancer
- A personal history of adenomatous polyps
- A personal history of colorectal cancer
- A person with inflammatory bowel disease, including Crohn's disease and ulcerative colitis

Screening is covered at a frequency of once every 2 years (at least 23 months from the last screening colonoscopy) for individuals at high risk of colorectal cancer.

58. My physician stated that he is going to perform TIF procedures. What is it and how do I code it?

TIF stands for Transoral Incisionless Fundoplication. The procedure, which is performed through the mouth, reconstructs the barrier between the esophagus and the stomach, thus preventing reflux of stomach fluids back into the esophagus. There is no specific code for this procedure. You can bill 43499 (unlisted procedure of esophagus). Make sure you verify coverage with the patient's carrier before the procedure.

59. We have many patients that require an interpreter to accompany them for office appointments at our expense. Even though we confirm the appointment with the patient the day before, often the patient is a "no show." We then have to pay for an interpreter that was not needed. Are we allowed to bill the patient or the insurance company for the cost of the interpreter?

You cannot charge for interpreter. However, you can charge a patient "no show" fee, as long as they are informed of your policies at the time of scheduling.

60. Our physician requests patients to bring in a frozen stool specimen to test for H pylori bacteria. The specimen is prepared in the office and is sent to the lab for analysis. Can we bill for stool specimen preparation, or does the lab bill the entire service? If yes, what CPT code would we bill?

If the physician does the preparation and pays for the supplies to do it, then you can bill 87338 with a TC modifier. This test is not paid for by some payors.

61. My physician sometimes dictates bipolar current and sometimes uses the term hot biopsy. What is the difference?

Bipolar current does not require the use of a grounding pad because the current runs from one portion

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of the tip of the device to another portion. Hot biopsy forceps use a monopolar current requiring the use of a grounding pad placed somewhere on the patient's body. Both are coded as hot biopsy.

62. My physician performed a drainage of a pancreatic pseudocyst. Can I bill for the ultrasound and fluoroscopy with this?

Endoscopy with drainage of pancreatic pseudocyst (43240) describes a procedure where the standard endoscope is inserted and the site for drainage of the pseudocyst is identified usually through the posterior wall of the stomach. A needle is passed through the scope to the site and the needle is inserted through the small intestine wall into the pancreatic pseudocyst. The pseudocyst is then drained.

Endoscopic ultrasound may be used and is separately billable. In addition to 43240, code 43242 for EUS guided aspiration. As of 10-01-09, fluoroscopy is bundled with all endoscopic procedures. Stents may often be inserted at the time of the drainage and those can be separately billed as 43256.

63. I know our practice will eventually have an audit by RAC (Recovery Audit Contractors). What areas are they focusing on for GI practices?

The areas affecting GI practices include:

1. Stark Violations. Physicians referring patients to services in which they or a family member have a financial interest.
2. Pharmaceutical Coding in Physician Offices. Auditors are checking for incorrect use of codes or units in billing of injections for drugs such as Remicade and Cimzia.
3. Medical Necessity. Documentation not supporting the level of service provided in the outpatient setting.
4. Incident-to Errors. Physician assistants and nurse practitioners performing services for a physician but specific billing guidelines related to the physician's relationship to the patient and the physician's presence in the office are not followed.

Other RAC issues include inappropriate /inaccurate usage of modifiers, signatures not on medical records, nonspecific diagnosis codes, and location of lesions and method of removal not specifically documented.

The best advice is to conduct an internal audit/assessment for compliance for Medicare rules. These internal findings will provide a basis for specific training for your providers/practice staff.

64. The practice that I work for is joining a hospital system. I have been told I will have to work with the 3 Day Rule. What is it exactly?

Is the practice going to be wholly owned by the hospital? If so, as of July 1, 2012, any services completed in the office setting are subject to facility fee reductions if the patient is admitted to the hospital within 72 hours of the office visit for reasons related to the office encounter.

Example: A patient with Crohn's disease is admitted to the hospital from the Emergency Room with

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severe abdominal pain and diarrhea 48 hours after a follow-up visit in the office for the disease. A PD modifier should be added to the office visit E/M code and the provider will get paid facility rates instead of office rates.

Keep in mind that you will have to know how you will be notified of the admission and who will be determining if the admission is related to the office encounter. You may need to hold office claims for 72 hours in case patients are admitted to the hospital within that 72 hour window.

65. My physician performed a “three dimensional motility test” of the esophagus. Is there a specific code for this?

There is no CPT code specific to “three dimensional motility.” Codes 91010/91013 should be reported if the patient underwent standard or high-resolution manometry. Codes 0240T/0241T should be reported if the patient underwent high-resolution esophageal pressure topography (HREPT). If performed in an outpatient or inpatient setting, the modifier 26 would be added to the procedure to indicate that only the physician interpretation was performed. Some payors may consider HREPT to be investigational and not allow coverage, so make sure that verification of benefits is done on every patient at the time of scheduling. Your physician may wish to create a “Letter of Necessity” for this procedure to payors.

66. Can I bill 43263 twice if my physician performed an ERCP and obtained pressure measurement readings in both the pancreatic and common bile ducts?

Yes, if measurements are obtained in both ducts, the code can be reported twice with the modifier -59 on the second procedure.

67. What diagnosis code is best to use for a patient who has had a previous cecostomy?

If you want to indicate that the patient has a cecostomy you would use V44.4. This code per ICD-9 instructions is not considered a primary diagnosis and can trigger a rejection if used as the initial diagnosis code on the claim. If the physician is addressing a complication with the cecostomy, then you would need to use a complication code. The range of those codes would be from 569.61 through 569.69, depending on type of complication.

68. When my physician removes a biliary stent endoscopically and not by ERCP technique, is the correct code 43247?

As per correct coding initiative (CCI) policy, chapter six, section C, #9, the removal of therapeutic devices previously placed is not to be billed as foreign body removal so only standard endoscopy code such as 43235 can be billed.

69. What is Optical Endomicroscopy?

Optical Endomicroscopy, also known as Confocal Laser Endomicroscopy, involves a very small powerful

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fiber optic microscope which fits through a standard endoscope. It magnifies tissue at the cellular level thus enabling the physician to look for abnormalities below the surface lining of the digestive tract. This is particularly useful in evaluating for Barrett's Esophagus. At this time, only upper GI codes have been established. As of January 1 2013, the CPT codes 43206 and 43252 can be used as appropriate.

70. My physician wants to start using a capsule to measure GI transit and pressures measurements from the stomach through the colon. How does this work? Is there a special code to use for billing?

These capsules have been developed to investigate functional gastrointestinal disorders including gastroparesis and functional constipation. The patient swallows a wireless capsule while wearing a special receiver on their hip. As the capsule travels through the patient's GI tract, data is transmitted to the receiver measuring pressure, pH and temperature. After the data is received from the stomach, small bowel, and colon, it is transferred from the receiver to a computer for analysis by the companion software. As always, verify eligibility before scheduling the patient as indications and coverage will vary per carrier. The code 91112 should be used beginning in 2013.

71. Is there a new code for fecal bacteriotherapy?

Fecal bacteriotherapy or fecal transplant is used in the treatment of *Clostridium difficile* (*C. diff*). Centers for Medicare and Medicaid Services (CMS) created the Healthcare Common Procedure Coding System (HCPS) code G0455 to describe the preparation and instillation of fecal matter "by any method". This includes the assessment of a donor specimen. For commercial carriers use the code 44705 for the preparation. As always, verify eligibility before the procedure.

72. What is a GIST and how do I code it?

Gastrointestinal stromal tumors (GIST) are not common, with only 5,000 cases diagnosed in the United States each year. The tumors can be malignant or benign. They can originate anywhere in the gastrointestinal tract from the esophagus to the rectum but the majority are found in the stomach (60%) and small intestine (30%). There is no specific ICD code. The code would depend on the pathology report stating if malignant or benign and the location of the GIST.

73. My physician managed care and performed an upper GI endoscopy on a patient in the critical care unit. What are the guidelines for billing this?

When billing critical care services the place of service can be in any location, such as the emergency room, endoscopy suite, or intensive care unit. The billing is diagnosis-driven so appropriate codes would include conditions such as shock, failure, and acute blood loss anemia. Just because the patient is in the ICU, doesn't necessarily mean that you can bill critical care services. Documentation should indicate the severity of the patient's condition and the physician's medical management. Time has to be documented with stop and start format mandate by some payors, including Medicaid providers. Total time can also

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be documented based on the total time in a period from midnight to midnight on the same calendar date. When submitting the charges, the use of the comment field/box/line (field 19) to enter the start/stop format and/or total time is recommended to avoid the claim being pended for review. Use code 99291 for the first hour and 99292 for each additional 30 minutes. The time spent performing the procedure has to be subtracted from the total critical care time. Example: Spent 2 hours from 1300 to 1500 with the patient with 30 minutes doing upper GI endoscopy so 90 minutes of critical care time would be billed using codes 99291 and 99292.

74. *Is there is a specific screening code when a flexible sigmoidoscopy is performed? If so, would it be a different code if the patient has a history of colon cancer and colon polyps?*

The code for average risk screening by sigmoidoscopy is G0104. There is no code for high risk flexible sigmoidoscopy so you would bill 45330 with the diagnosis of V10.05 and/or V12.72.

75. *My physician wants to bill for the IV start and supplies for infusions. Is that allowable?*

A therapeutic, prophylactic or diagnostic IV infusion or injection (90765-90788) not given for hydration is for the administration of substances/drugs. Report the drugs used with the appropriate J code. The fluid used to administer the drug(s) is incidental hydration and is not separately billable. Per CPT instructions the following are included and also NOT reported separately: a) IV start b) use of local anesthesia c) standard tubing, syringes and supplies.

76. *What is included in time-based billing in the hospital setting?*

2013 CPT changes included clarification of time-based billing for unit/floor time (e.g., hospital observation services, inpatient care, hospital consultations). For reporting purposes, it is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

77. *What is a Split/Shared visit?*

Medicare Part B payment policy defines a split/shared Evaluation/Management (E/M) visit as a medically necessary encounter with the patient where the physician and a qualified NPP (Non-Physician Provider) each personally perform a substantive portion of an E/M visit that must include face to-to-face interaction with the same patient on the same day of service. A substantive portion of an E/M involves all or some portion of the history, exam, or medical decision-making as key components of an E/M service. Documentation from each is considered/combined to possibly reach a higher level of service for billing purposes under the physician. The physician and the NPP must be in the group practice or employed by the same employer. The split/shared visit applies only to select E/M visits and settings, such as hospital, inpatient and observation, emergency department, and hospital discharge services. The split/shared

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E/M policy does not apply to critical care services or procedures.

78. What is the correct code for billing High Resolution Esophageal Pressure Topography (HREPT)?

HREPT is used to view the contractility of the entire esophagus simultaneously in a uniform format. The correct code is 0240T. If stimulation and/or perfusion is performed during the HREPT, then report 0241T in addition to the 0240T. If performed in a hospital setting, then modifier 26 should be added to the procedure to indicate that only physician interpretation was performed. Make sure to verify benefits on every patient when scheduling this procedure, as it is not covered by all payers.

79. Our office received a consult for one of our physicians. His nurse practitioner saw the patient, discussed the case with the physician, and then dictated the history, exam, and treatment plan. Can this be billed “incident to”?

Consultations in any location and new patients visits in the office cannot be billed “incident to” even if during that visit the physician sees the patient after the nurse practitioner. The service should be billed under the NPP’s (Non-Physician Provider) provider number.

80. My physician wants an office visit to examine a donor before a fecal transplant. What code should I use for the pre-donation visit?

An office visit/exam of the donor is not required or covered by any specific code. Preparation of the fecal microbiota for instillation includes screening for hepatitis and HIV from the donor specimen. Medicare code G0455 also includes any method of instillation, including colonoscopy. Commercial code 44705 includes the assessment/testing of the donor specimen and upper GI instillation, but not lower GI instillation. This is not covered by all carriers; make sure to verify coverage/benefit.

81. Our practice owns a building that houses both the physician offices and our Ambulatory Surgery Center (ASC). Is it correct to bill place of service (POS) 11 for the physician charge and POS 24 for the facility charge?

Per the Centers for Medicare and Medicaid Services (CMS), if the physician services are not related to services being provided in the ASC then POS 11 is correct. If the services are related to services being done at the ASC (e.g., a colonoscopy) then it would be POS 24.

82. Can we bill a separate evaluation/management (E/M) visit with a 25 modifier when our physicians examine the patient and dictate a history and physical immediately before performing a procedure at a surgery center?

No. Per CMS guidelines, modifier 25 cannot be used on the same day as a pre-planned procedure. A facility requirement for a history and physical prior to a procedure is not a distinct service and does not justify billing for a separate E/M service.

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83. My physician performed a biopsy of the small intestine using a side viewing scope. Is there a specific code for this scope?

The type or model of scope does not influence the code choice. Codes should be based on what actions are taken during the procedure and on the location.

84. My physician rarely provides critical care services. When we do bill for critical care, we have trouble receiving reimbursement. Are there special guidelines that we should be following?

Time has to be documented, preferably in a start and stop format. Total time in a 24 hour period can also be documented (e.g., midnight to midnight on the same calendar date). When submitting charges use the comment field/box/line (field 19) and enter critical care time found on progress notes to avoid pended claims.

Also, recommend that your provider copy the note so it can be submitted with the charges. Place of service can be any location where the care was given such as the emergency room, endoscopy suite, or office. The documentation has to indicate the severity of the patient's condition and should be supported by a diagnosis that indicates the severity such as shock or acute blood loss anemia. Bill 99291 for the first hour and 99292 for each additional 30 minutes.

85. We are trying to pre-certify a patient for a CT enterography. What are the correct CPT code(s)?

CT enterography is not a specific procedure but rather a protocol used with CT abdomen, CT pelvis or CT abdomen and pelvis. It uses CT imaging and two types of contrast to better visualize the anatomy of the interior small intestines. The codes would be:

- 74176 Computed tomography, abdomen and pelvis; without contrast material.
- 74177 Computed tomography, abdomen and pelvis; with contrast material(s).
- 74178 Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions.

86. When my physician performs an endoscopic drainage of a pancreatic pseudo cyst, are there any additional charges I can bill or am I limited to just 43240?

43240 describes the procedure where a standard endoscopy scope is inserted and the site for drainage of the pseudo cyst is identified usually through the posterior wall of the stomach. A needle is passed through the scope to the site. The needle is inserted through the small intestinal wall into the pancreatic pseudo cyst to allow drainage. Often stents are inserted at the time of drainage and those can be separately billed. Fluoroscopy is included in any endoscopic procedure and should not be billed. However, endoscopic ultrasound may be used for the procedure which would be separately billable.

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87. *Is a patient with private insurance liable for cost sharing when a screening colonoscopy becomes diagnostic?*

Colonoscopy cost sharing has been eliminated for privately insured patients. On February 25, 2013, the federal government issued a clarification on preventative screening benefits under the Affordable Care Act. Patients with private insurance are no longer liable for cost sharing when a pre-cancerous colon polyp is removed during a screening colonoscopy. This ensures colorectal cancer screening is available to privately insured patients at no additional cost, as was intended by the new healthcare law. Patients with Medicare coverage must still pay a coinsurance when a polyp is removed as a result of the screening colonoscopy. Remember to check coverage since some payers are exempt from the Affordable Care Act if they manage privately funded plans.

88. *My physician interpreted a Bravo on an outpatient with Medicare at the hospital. How should this be coded?*

If the hospital owns the equipment, the patient comes back to the hospital for downloading and your physician interprets the test, then the place of service would be OH (outpatient hospital) - code 22. Your place of service would be OH with a 26 modifier submitted on 91035 for interpretation only. This applies to all patients—not just Medicare patients.

89. *Our practice is starting to use the Fibroscan. What CPT code can we use to submit a claim?*

Fibroscan is used in the clinical management of patients with liver disease such as chronic viral hepatitis C and B and fatty liver disease. It is sometimes used as an alternative to a liver biopsy. This technology received approval on April 16, 2013 from the Federal Drug Administration. At this time there is no specific CPT code assigned and 91299 should be submitted. As always, with any new technology or procedure, verification of eligibility should be done prior to scheduling.

90. *My physician is using an injectable bulking agent to treat fecal incontinence. What are the CPT and diagnosis codes that I can use?*

The CPT code would be 46999: Unlisted procedure, anus. Common diagnosis codes would include: 787.60 Full incontinence of feces, 787.61 Incomplete defecation, 787.62 Fecal smearing, and 787.63 Fecal urgency.

91. *My physician is planning on using a vibrant capsule. What is it and how do I bill for it?*

The vibrant capsule is used in the treatment of constipation. The capsule vibrates on the wall of the colon which induces a natural peristaltic activity, generating spontaneous additional bowel movement. Currently it has not met FDA approval but once approved will be submitted as 91299. This will require verification of eligibility since most payers will not cover initially.

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
AAPC

92. What is the CMS “Two Midnight Rule”?

This rule became effective October 1, 2013. It states that after the patient stays two midnights, the hospital stay converts from observation to an inpatient stay. Even though gastroenterologists are not usually the admitting providers, there will be some investigation by RAC (Recovery Audit Contractor) to ensure that the care has not been delayed in order to obtain “inpatient status”.

93. Is it true that colonoscopy cost sharing was eliminated for privately insured patients?

On February 25, 2013 the Federal government issued an important clarification regarding preventative screening benefits under the Affordable Care Act (ACA). Patients with private insurance will no longer be liable for cost sharing when a pre-cancerous colon polyp is removed during a screening colonoscopy. This ensures that colorectal cancer screening is available to privately insured patients at no additional cost which was the intent of the new health care law. Patients with Medicare coverage must still pay coinsurance when a polyp is removed as a result of the screening colonoscopy, but their deductibles are waived. There are “grandfathered” plans that are exempt from the ACA. When performing preauthorization and eligibility/predetermination, it is recommended that staff members ask if this is a “grandfathered plan”. If so, the patient does need to be informed that there most likely will be “cost sharing” and potential patient responsibility should be discussed at the time of scheduling.

94. My physician states that the submucosal injection code, 43236, has been unbundled. Is this true and how do I correctly bill?

Yes, there was a change on code 43236 (upper GI endoscopy with submucosal injection). It was bundled with any endoscopic procedure in the upper GI tract. Effective October 1, 2013, 43236 can be billed in conjunction with 43251 (EGD with snare). The combination of submucosal injection and snare is often used for the excision of larger lesions. This change is retroactive to January 1, 2013. Practices should run a report on code 43251 to see if 43236 could be billed. The ability to go back and bill this code will be dependent upon the payer’s timely filing limits.

95. At what age does Medicare stop covering average risk screening colonoscopies?

Average risk screenings are limited to those between the ages of 50-75. This is reflected in the PQRS measure 113. High-risk screenings do not have age limitations.

96. My physician performed an esophagogastroduodenoscopy (EGD) but was unable to examine the duodenum. What is the correct modifier in this circumstance?

There are times that the duodenum is deliberately not examined during an EGD. Reasons for this include the physician judging it not to be clinically pertinent or a condition such as severe gastric retention precludes the safe examination of the duodenum. Append modifier 52 if your physician does

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
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not plan on repeating the exam or modifier 53 if a repeat exam is planned.

97. *Is an esophagoscopy limited strictly to the esophagus?*

An esophagoscopy has been specifically defined to include the examination from the cricopharyngeus muscle (upper esophageal sphincter) up to and including the gastroesophageal junction. Also it may include examination of the proximal region of the stomach via retroflexion when performed.

98. *Can I bill a dilatation of a ductal stricture in addition to a stone removal during an ERCP (endoscopic retrograde cholangio-pancreatography)?*

Code 43264 includes removal of calculi or debris from duct(s). Code 43277 may be reported if a sphincteroplasty or dilation of a ductal stricture is required before proceeding to the removal of stones or debris from the duct during the same session. Dilation that is incidental to the passage of an instrument to clear the stones, sludge or debris is not separately reported.

99. *My physician performed an Endoscopic Retrograde Cholangiopancreatography (ERCP) but was unable to cannulate the pancreatic duct. What is the correct way to code this?*

An ERCP is considered complete if one or more of the ductal system(s), (pancreatic/biliary) is/are visualized. To report an attempted ERCP, but with unsuccessful cannulation of any ductal system, see codes 43235-43259. Code 43260-53 should no longer be used.

100. *My doctor removed a biliary stent using a snare, but did not do an Endoscopic Retrograde Cholangiopancreatography (ERCP). How should this procedure be billed?*

Since January 1, 2014, this would be considered an EGD with removal of foreign body. The CCI policy is listed below. This is found in Chapter 6, Section C, #9:

9. Intubation of the gastrointestinal tract (e.g., percutaneous placement of G-tube) includes subsequent removal of the tube. CPT codes such as 43247 (upper gastrointestinal endoscopic removal of foreign body) should not be reported for routine removal of previously placed therapeutic devices. If a previously placed therapeutic device must be removed endoscopically because it cannot be removed by a non-endoscopic procedure, a CPT code such as 43247 may be reported for the endoscopic removal.

101. *My physician stated that a patient had a Dieulafoy's lesion of the stomach. What is that and how would I code the condition?*

Dieulafoy's lesion is a tortuous, submucosal arterial malformation which has a propensity to bleed. Most are located in the stomach, but they can be found in the duodenum, jejunum, ileum, colon and esophagus. The occurrence is rare, causing approximately 5% of gastrointestinal bleeding in adults. The clinical presentation is painless, massive bleeding. The condition, which is not familial, is more prevalent

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
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in males and can occur at an age. The ICD-9 code is 537.84. The ICD-10 code will be K31.82.

102. A physician in our practice plans on performing an EGD on a patient that has had a previous Billroth II. Are there special codes that would apply to this situation?

Codes 43233, 43235, 43259, 43266, and 43270 should be used for the examination of a surgically altered stomach where the jejunum is examined distal to the anastomosis site on patients who have had a gastroenterostomy (Billroth II) or gastric bypass.

103. My physician stated that we should be reporting Category II codes for a screening colonoscopy. Can you please clarify what this means?

Category II codes describe clinical conditions and topics with which performance measures are reported. According to a notice on the American Medical Association's website, on April 1, 2014 two colonoscopy Category II codes were implemented for adenoma or other neoplasm detection during a screening colonoscopy. Reporting of these codes is optional. CPT code 3775 F should be used if adenomas or other neoplasms are detected during the screening colonoscopy. Code 3776 F should be reported if none are detected during the screening procedure.

These codes will be published in the 2015 CPT manual, but the reporting could have been initiated in April 2014. Remember that this only applies to adenomas or neoplasms, not hyperplastic polyps. Since it is not approved for hyperplastic polyps, this means that you would have to wait for pathology results before submitting the endoscopy procedure with the quality measures since quality measures can never be reported without a corresponding CPT/HCPCS code.

104. I am considering adding a nutritional/weight loss clinic to my practice. Is a dietitian required for this service? Are there billing guidelines?

Nutritional and weight loss counseling can be performed by non-physician providers such as nurse practitioners and physician assistants. The billing would utilize standard Evaluation and Management (E/M) codes based on time through counseling and coordination of care.

Registered dietitians can provide the service and billing should be submitted under their corresponding NPI (National Provider Identifier) numbers, the use of group or individual counseling can be based on time documentation.

Medicare does not recognize this for all medical conditions. Pre-determination should be done on patients with commercial insurance. Non-covered conditions can utilize a cash-pay scenario.

105. Does the three year rule for new versus established patients apply in a hospital setting?

The three year rule does not apply to inpatients but it does apply to observation patients. If the provider or anyone in their group has seen the patient at any location (hospital, emergency room, clinic or office) within the past three years then this is considered an established patient and only the established visit

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
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codes are allowed under Medicare guidelines (this applies even if the patient is being seen for a new problem). The provider seeing the patient in the hospital is often unaware that this patient might have been seen by anyone in the GI group prior to this encounter, so that is why it is essential to verify patient status prior to entering the charges.

106. What should be documented on the capsule endoscopy report and/or any other diagnostic studies interpreted by the GI physicians/providers?

There should be an indication, finding, brief patient history, detailed description of the test, recommendations, date of placement/swallowing, date of download, date of interpretation, and legal signature. There are usually computerized data available on some of the studies and that should also be in the medical record. Billing for these studies can vary among payers so it is important to gather the most current information from your payers. Some payers including Medicare require the date of interpretation to be the billing date, while others require the date of initiation.

107. If a physician sees an observation patient covered by Medicare for the first time but the physician was not the admitting physician what CPT codes range do we use?

The provider would report new or established office/outpatient E/M codes 99201–99205, 99212–99215 if the patient is admitted to observation status. Make sure the patient has not been admitted to inpatient status. In that case you would report a code from 99231–99233.

The guidance can be found in the Medicare Claims Processing Manual Ch. 12 30.6.8.B “payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient’s observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.”

108. Can CPT codes 43242 and 43259 be reported on the same claim?

Codes 43242 and 43259 cannot be reported together under any circumstances according to NCCI Edits. The rule states that 43259 is bundled into code 43242. For this case the only appropriate code would be 43242. Also the CPT® code description for 43242 includes “endoscopic ultrasound examination.”

109. My doctor performed an upper EUS with FNA. FNA was done of the celiac lymph node, gastro-hepatic lymph node, and pyloric lymph node. I will use code 43242 but since the FNA was done of multiple sites can I bill additionally: 43242-59, 43242-59 and 43239-59?

The code description for 43242 accounts for more than one biopsy as shown below:

Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
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examined distal to the anastomosis).

There's also a medically unlikely edit (MUE) that indicates that this code should only be reported once.

110. While a colonoscopy was performed a decompression tube was inserted over a wire. Based on my research I think that we should only be billing 45378; however, I want to make sure that I am using the most appropriate code.

Yes, the code 45378 is correct for a colonoscopy with decompression. An additional code is not warranted.

111. I received a denial for code 43255 citing it is incidental to the 43270 which was paid. I can't find any documentation on the 43270 that shows these codes together are mutually exclusive.

There is an NCCI edit for this code combination. 43255 is a column 2 code for 43270. The control of bleeding that resulted due to an endoscopic procedure is not reported separately. If the control of bleeding is not a result of the endoscopic procedure it can be reported with modifier 59.

112. A patient was seen for a colonoscopy. During the procedure the scope was unable to advance past the sigmoid due to an obstruction/mass. Biopsy was taken. In this instance should we bill for a limited colonoscopy with biopsy or sigmoidoscopy with biopsy?

In CPT® 2015 there is clarification and a decision tree added to help you determine the appropriate modifier. Modifier 52 is appended if the scope is advanced beyond the splenic flexure but not all the way to the cecum and a biopsy is taken. If the splenic flexure is not reached, report as a flexible sigmoidoscopy with biopsy. If a diagnostic colonoscopy is performed beyond the splenic flexure but not all the way to the cecum, use modifier 53 instead.

113. We continue to have ongoing discussions (i.e., disagreements) regarding the proper use of the V76.51 code. If we have a patient with a family history or polyps or colon cancer, can we use the V76.51 and V18.51 together with the V76.51 being primary? And if the patient returns 5 years later, without any findings on the first procedure, for a follow-up colonoscopy for the same reason can we use the V76.51 again?

A screening code may be a first listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. In this case, the reason for the procedure is the screening. The family history is a contributing factor and indicates the patient's level of risk.

114. If a patient has ulcerative colitis and is asymptomatic but the physician is scheduling colonoscopies every 2–5 years for the UC, how should this be coded, specifically for commercial payers? Is this considered a true "screening" that should be paid under screening benefits?

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Vice President, ICD-10 Training and Education
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According to the ICD-9-CM Coding Guidelines, the testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test. You would report the appropriate diagnostic CPT code.

115. If a patient had a stent exchanged in the Common Bile Duct, is it possible to also bill for the removal of the Pancreatic stent, considering different ducts?

Yes, you can bill the removal of stents from different ducts. If you notice at the end of the code description it states: "each stent exchanged", there's also a note that states (43276 includes removal and replacement [exchange] of one stent. For replacement [exchange] of additional stent[s] during the same session, report 43276 with modifier 59 or appropriate X modifier for each additional replacement [exchange]).

116. What code do you use for a Upper gastrointestinal endoscopy that turns in to a enteroscopy (the enteroscope was advanced well into the jejunum).

In this case, as long as the documentation supports it you can bill the code 44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure). The description of the procedure includes the inspection of the mucosal lining of the esophagus, stomach, upper portion of the duodenum, and also the second portion of the duodenum. The provider inspects the area beyond the second part of the duodenum and may include all of the jejunum but not the ileum.

117. We have some confusion as to the verbiage in the report that we should be looking for to identify an endoscopic mucosal resection (EMR). We would like some clarification/understanding of the CPT 45390, colo w/EMR. Is it the same as a (45385) polypectomy with saline injection to lift (45381)? If we see this verbiage are we to assume that this is in fact an EMR and should be billing 45390?

CPT 45390 is reported instead of 45385 and 45381. If the provider performs a lift with snare excision, report as EMR. EMR can include injection-assisted, cap-assisted and ligation-assisted techniques. All techniques involve 1) Identification and demarcation of the lesion; 2) Submucosal injection to lift the lesion; and 3) Endoscopic snare resection. Do not report submucosal injection, banding or snare polypectomy separately because the services are bundled with 45390.

118. Should we be billing Medicare claims with modifiers, XE, XS, XP, or XU in place of modifier 59?

Yes if your MAC is accepting the XE, XS, XP, and XU modifiers. Some private payers are also accepting the new modifiers. It is recommended for you to contact your payer or review the payer website for instructions regarding the new modifiers.

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
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119. One of our technologists believes that it is appropriate to bill twice for both 78264 and the radiopharmaceutical when performing the gastric emptying study with liquid and solid food; it is my understanding that the standard for the test is to perform with both liquid and solid food, and therefore should only be billed once for the entire study (performed on the same day). Can you please clarify?

A Gastric Emptying Scan is a nuclear medicine test that determines how fast the stomach empties food into the small intestine after eating. After ingestion of a meal with small amounts of radioactive material, images are obtained to detect the distribution of the radioactive energy in the body. This provides a recording of the emptying progression as the food leaves the stomach. CPT Code 78264 Gastric Emptying solid/liquid is billed once. However, if the physician needs to repeat the study on the same date of service, append modifier 76 to the second study.

120. Can a provider bill for a consult on a patient they have seen for a procedure and deem it necessary for the patient to be admitted? For example, a physician performs an EGD on a patient for anemia and a GI bleed is found. The physician finds that the patient is unstable after the procedure has concluded and requests that the patient be admitted by the hospitalist service. Can the GI physician then consult on this patient that he is requesting be admitted?

This would not be a consultation. A consultation is performed at the request of another provider. Because the determination to have the patient admitted is performed following the procedure, you would not report an E/M service. The hospitalist would bill for the admission.

121. What is the CPT code for a flexible sigmoidoscopy with endoscopic mucosal resection?

The CPT code for this procedure is 45349 *Sigmoidoscopy, flexible; with endoscopic mucosal resection.*

122. My doctor performed an EGD with biopsy. He went past the duodenum and to the jejunal loop. What CPT code do I use for that?

The correct code for this service is 44361 *Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple.*

123. I have a procedure scheduled as ERCP. The esophagus and stomach are normal. There was some difficulty getting into the duodenum as the pylorus was eccentrically placed due to the pancreatic fluid collection or pancreatic necrosis. However, the duodenum was cannulated with the ERCP scope and duodenum findings revealed a small opening where the ampulla is supposed to be, draining creamish liquid. This opening was entered using a wire that crossed the spine and then dye was injected. Injection of dye did not delineate the pancreatic duct suggesting no intact pancreatic duct remaining. Is this reported with 43260?

Yes, 43260 is reported. Code 43273 is also reported for the cannulation.

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Rhonda Buckholtz, CPC, CPMA, CPCI, CGSC, CPEDC, CENTC
Vice President, ICD-10 Training and Education
AAPC

124. I have been told that a 45383 (ablation of a polyp) was going to be coded with 45388 in 2015 but now that is not working either. They were supposed to do away with 45383 - deleted code. How should this procedure be reported?

If you are billing Medicare, you have to report G6024 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.

125. Can we still use modifiers 25, 59, TC, 26 for claims with dates of service after 10/1/15?

Yes modifier 25, TC and 26 are all acceptable modifiers. Some payers will accept or require XE, XP, XS, or XU instead of modifier 59. The implementation of ICD-10-CM codes does not affect the reporting of CPT®, HCPCS Level II or the proper use of modifiers.

126. We know that if a patient has a history of polyps, and they return to have a repeat surveillance colonoscopy years later, that it is not a screening colonoscopy. It is billed as a preventative service, with the personal history of colon polyps as the dx. But if a polyp is hyperplastic, instead of adenomatous, would it still be a surveillance colonoscopy or would the provider be able to bill a screening colonoscopy? Also, if the reason for the procedure in less than 10 years is due to a patient's family history of colon cancer (and the patient had small benign hyperplastic polyps), can one add the Z12.11 screening code to the history code?

The history of hyperplastic colon polyps are considered a nuisance and not threatening. The patient would have to wait 10 years for follow-up. However, the family history of adenomas allows consideration for colonoscopy and polypectomy every 3–5 years; if multiple polyps are found, colonoscopy every 1–3 years depending on type, number, and size of polyps.

The family code Z80.0 would be the first listed diagnosis. Yes, Z12.11 can be reported as an additional diagnosis.

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