Gastroenterology Coding Alert

Upper GI Coding: 4 FAQs Help Guide Your Upper GI Coding Choices

Determine where the scope went to pinpoint the right code.

Coding Upper GI procedures can present myriad questions, such as how to bill when your gastroenterologist takes the endoscope past the proximal duodenum. Do you report an esophagogastroduodenoscopy (EGD) or a push enteroscopy? To save hours of research and frustration tracking down the answers to this and other conundrums, read on, because we've compiled the questions most often sent to Gastroenterology Coding Alert on this topic, along with expert answers.

FAQ 1: How Do We Match the Scope Location to the Code?

Before you can understand the details of upper GI coding, it's a good idea to familiarize yourself with a basic checklist of which codes pair with which scope locations, as follows:

- **Scope limited to esophagus:** Choose esophagoscopy codes 43180-43233 to report an endoscopic examination of the esophagus even if the gastroenterologist incidentally enters the stomach, as may happen if the physician needs to gain a retroflex view back at the cardia. You can choose options from the parent codes 43191 (Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen[s] by brushing or washing when performed [separate procedure]) or 43200 (Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed [separate procedure]).
- **Scope limited up to duodenum:** Go for EGD codes 43235-43259, 43210, or 43270; such as base EGD code 43235 (Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]), when your gastroenterologist passes the pylorus with the endoscope. Even if the physician passes the pylorus and enters the jejunum due to an altered anatomy such as a Billroth II to examine the upper GI tract or after bariatric surgery, you should choose a code from the EGD (43235) family.
- **Scope passes second portion of duodenum:** You can code for enteroscopy (44360-44379), such as base code 44360 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing [separate procedure]) once the scope passes at least 50 cm beyond the pylorus, which is clear from the introductory language to the section of codes for enteroscopy. "The descriptor for 44360 still refers to 'beyond second portion of duodenum,' but it is important to document the distance traversed and to look for that language in a report in order to bill accurately," says **Glenn Littenberg MD**, a gastroenterologist in Pasadena, Calif. To appropriately report codes from the 44360 series, you have to have medical necessity to examine the jejunum. The physician typically accesses well beyond the ligament of Treitz area and well into the jejunum.

FAQ 2: Can We Report Upper GI Enteroscopy For Incidental Looks Beyond the Proximal Duodenum?

No, you shouldn't code an upper GI enteroscopy for an incidental look beyond the proximal duodenum. Patient charts and op notes are your closest allies for correctly assessing your physician's scope and intention of endoscopy.

Focus on this: You should only report what your physician has stated as his focus or intention for the scope examination. Occasionally, a physician may take a quick look past the duodenum through the scope. However, you should steer well clear of coding this as 44361 if the physician's documentation doesn't show that there's a medically necessary reason. Even the prior patient chart notes must support the gastroenterologist's reason for going that far.

Usually, the physician will document that his "intent" is to do an EGD. Clinically, he is just being thorough when he goes beyond the second portion of the duodenum. This becomes a problem when coders report all EGDs that document

"beyond the second portion of the duodenum" as enteroscopies. Be on the lookout as the physician will note if he is going to perform a enteroscopy, then he will document that and will only be looking in the small bowel.

In many cases, the procedure will be scheduled as a "push enteroscopy" and the instrument used for the procedure will be a pediatric colonoscope or a long enteroscope and it will not be the standard upper endoscope.

FAQ 3: How Does CCI Impact These Codes?

For a single procedure, you need to pick the most appropriate code from the 43235 or 44360 family. Be familiar with the Correct Coding Initiative (CCI) edits, which do not allow payment for the base EGD code (43235) with the enteroscopy code (44360) because the standard endoscopy procedure is included in the enteroscopy code by definition.

You should also avoid coding two codes from the same family together -- CCI bundles 43235 with codes such as 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple) and 44360 with 44361 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple). That's because the CPT® guidelines state that surgical/therapeutic endoscopy always includes diagnostic endoscopy.

Exception: However, in some cases there is a "1" modifier with the CCI edits that allow the use of otherwise bundled codes under unusual circumstances. For example, if two different instruments were needed for two different indications, then it may be possible to bypass the edit with a modifier such as 59 (Distinct procedural service), by providing the appropriate documentation.

FAQ 4: Does Place of Service Make a Difference?

The place of service is a key factor in determining the endoscopy payment you recoup. Even though push enteroscopy goes deeper, and you may think you would always get paid more for that procedure versus the EGD, it is not so.

Reasoning: The AMA considers an upper endoscopy with biopsy safe to perform in the office. Therefore, your gastroenterologist may perform the procedure in a "non-facility" setting. Sincethere is a significant additional practice expense payment for 43239, you'll actually earn more for the EGD in the office than you earn for the push enteroscopy--which can only be performed in a facility setting-- even though the push enteroscopy goes farther.

The difference: CMS assigns 4.67 relative value units (RVUs) for 44361 in both the facility and non-facility settings. However, code 43239 has only 4.08 RVUs in a facility setting but 9.73 in a non-facility setting (based on the 2017 Medicare Physician Fee Schedule, which pays 35.89 per RVU).

"Note that if a biopsy is performed during enteroscopy, even if the biopsy is from the esophagus, stomach or duodenum, the code 44361 still applies," Littenberg says.