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Internal Medicine Coding Alert

Case Study: Optimizing Pay-up for Multiple Endoscopic Procedures Performed on the Same Day

Internists who perform endoscopic procedures, particularly subspecialists in gastroenterology, often perform multiple procedures during a single use of the scope equipment inserted into a single body orifice.

For example, a physician may perform a colonoscopy to remove a polyp from one area of the colon, and, using the same pass of the scope, take a biopsy of another polyp in another area for further study.

Those are two related procedures in that you have gone through one orifice with the scope one time, but the procedures are two different procedures on two different polyps. Other times, the physician, in an attempt to diagnose a single problem, will perform multiple endoscopic procedures using separate scopes in separate body orifices at the same visit.

For example, a patient presents with rectal bleeding of an unknown origin. The physician performs an upper gastrointestinal endoscopy (43235, upper gastrointestinal endoscopy including esophagus, stomach and the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimens, by brushing or washing [separate procedure]). The cause is not determined. The physician then performs a diagnostic sigmoidoscopy (45330) and finds the cause of the bleeding.

Reporting both types of multiple procedures can be complicated because Medicare, as well as some private payers, have specific payment rules for multiple endoscopic procedures. Calculating appropriate reimbursement depends on the coders knowledge of whether the procedures are performed with a single scope insertion, or whether the procedures are the result of separate scope procedures in separate orifices.

We consulted **Glenn Littenberg, MD,** a practicing gastroenterologist in Pasadena, CA, a member of the American Medical Associations CPT Editorial Panel, and a member of the reimbursement and coding committee at the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), to clarify the correct way to report these procedures.

Family of Codes vs. Multiple Procedures

First, it is helpful to think in terms of family of codes and multiple procedures separately when reporting endoscopic procedures, Littenberg relates. Codes for endoscopic procedures that can be performed together with a single pass of the scope are grouped together in CPT as families of codes, with the main diagnostic scope code as the base procedure code, he explains.

For example, codes 45378-45385 are one family, with code 45378 (colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression [separate procedure]) as the base code for that family.

Multiple surgical endoscopic procedures performed at the same session can be reported individually. However, Medicare has special payment rules dictating the amount the second procedure will be reduced when both services are performed on the same day.

Note: See section below on reporting codes in the same family.

Multiple procedures are defined by Littenberg as endoscopic procedures performed on the same day, but using different

scopes through different body orifices. Codes for these procedures are from separate families of codes and are subject to Medicares normal multiple surgical procedures rules.

Reporting Codes in the Same Family

In the example at the beginning of this article, coders would look up the family of codes for diagnostic flexible colonoscopy, and two codes in that family would be reported for the two procedures performed45385 (colonoscopy, flexible ... with removal of tumor[s], polyp[s], or other lesion[s] by snare technique) and 45380 (with biopsy, single or multiple). According to CPT, surgical endoscopic procedures are considered to include the diagnostic scope procedure represented by the base code. So code 45378 cannot be reported in addition to 45380, because 45380 also includes the diagnostic colonoscopy.

When reimbursing for two endoscopic codes from the same family, Medicare payment rules state that the code with the highest allowable will be paid at 100 percent of the fee schedule. Remaining codes will be paid at the fee schedule amount minus the fee schedule amount for the base code. (See coding example in the chart on this page.)

The easiest way to think about it is that you are not repeating the diagnostic scope portion of the procedure when you do the second procedure, so that is why the payment rule takes the second code and subtracts the value of the base code from it, explains Littenberg.

Note: Littenberg also says that his office reports the codes with the full office charge for the code and lets the Medicare carrier reduce payment based on Medicares rules.

Littenberg also advises coders to report the code with the highest allowable first, to ensure that the procedures with lower allowables are reduced and the practice receives the highest possible reimbursement.

Add -59 Modifier to Codes in Same Family

When reporting endoscopic procedures in the same family on the same day, Littenberg advises coders to append the -59 modifier (distinct procedural service) to the code with the highest allowable.

You have to be more careful about modifier use, because there are many Correct Coding Initiative bundling rules with these codes, and proprietary software rules, he explains. But many times, when you are billing two procedures that are within the same family, unless you tell the carrier that the procedure is a separately identifiable service by using the modifier, they will generally assume that you are trying to unbundle something and they will deny one or both of the procedures.

The modifier indicates to the payer, for example, that you are not doing two things to the same polyp but doing a biopsy of one polyp and removing another separate lesion.

Some carriers may not recognize the -59 modifier, or may have edits that bundle the two specific endoscopic codes, Littenberg adds. He recommends reporting codes according to CPT, attaching the modifier to the code with the highest allowable as a starting point.

The best rule is to start out with the modifier -59 and, unless they have some other bundling rule, it should get paid, he notes.

Reporting Multiple Procedures

Reporting endoscopic procedures performed through separate orifices on the same day is simpler. Both codes can be reported individually. For example, in the second clinical example above, the code for the upper gastrointestinal endoscopy (43235) is reported in addition to the code for the sigmoidoscopy (45330). Medicare payment rules stipulate that the full fee schedule amount will be paid for the code with the highest allowable. Additional endoscopies will be paid at 50 percent of the amount listed on the fee schedule. The -51 modifier (multiple procedures) should be affixed to both

codes, notes Littenberg.

In reality, however, most Medicare carriers will assign that modifier even if you dont submit it, he advises. If you report an upper endoscopy and a colonoscopy and they both meet coverage criteria, even if you dont put the modifier on it, the carrier usually will automatically decrease the allowable on the second by 50 percent. They do, however, process it. I am not aware of payers that kick it out or deny it because the modifiers were left off.