Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Achieve Sigmoidoscopy Accuracy With 3 Quick Tips

Knowing the correct situations to report control of bleeding will help avoid denials.

With all the new CPT® and HCPCS changes to deal with, you may not have time to brush up on commonly-coded procedures such as sigmoidoscopies. Follow these three tips explained through our scenarios to extract the most out of your sigmoidoscopy reporting.

Tip 1: Sigmoidoscopy With Biopsy? Look Closer Before Coding

You are in safe territory if your gastroenterologist just performed a sigmoidoscopy with biopsy in a session and did not carry out any other service. You just report the CPT® code for standard sigmoidoscopy with biopsy. Here, the applicable code will be 45331 (Sigmoidoscopy, flexible; with biopsy, single or multiple). However, tread carefully if your physician resorts to other methods for completing the procedure.

For example, a patient reports to the office with a diagnosis of proctitis and continuous rectal bleeding. The gastroenterologist is not able to conduct the sigmoidoscopy normally and infuses formalin into the rectum for the procedure, which lasts for about 45 minutes. There is no direct code for formalin infusion, but the procedure has lengthened and turned more technical than a standard flexible sigmoidoscopy.

In such a case, you can report an E/M and a prolonged services code. You can code 45331 for the sigmoidoscopy, 99212 (Office or other outpatient visit for the evaluation and management of an established patient, ...) for the medical assessment and counseling for formalin infusion, 99354 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Management service]) to account for the extra E/M time. You can justify the service provided by attaching ICD-9 codes 569.3 (Hemorrhage of rectum and anus) and 569.49 (Other specified disorders of rectum and anus; other).

You'll need to be sure the provider has documented this adequately to justify medical necessity for the prolonged services code (99354). As 99354 is an add-on code, remember to first include the main E/M code (represented by 99212 in our example).

The documentation should describe in detail the service the gastroenterologist provided during the prolonged service time and his explanation for the need of the prolonged physician service. Look particularly for reasons for initiating the formalin infusion.

Tip 2: Steer Clear of Coding Bleeding Control With Sigmoidoscopy

Let's say that your GI is conducting a diagnostic sigmoidoscopy and has to perform control of bleeding subsequently. You would think that you can report both codes 45330 (Sigmoidoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) and 45334 (Sigmoidoscopy, flexible; with control of bleeding, any method) together. If you do that, you'll be heading into denial country.

"New language in CPT® 2015 clearly states that you can't report control of bleeding separately when bleeding occurs as the result of an endoscopic procedure during the same operative session. You can only report control of bleeding if it was the main reason for the procedure," informs **Michael Weinstein, MD**, Vice President of Capital Digestive Care.

You should also note that previous code descriptors for control of bleeding codes included a list of examples such as

injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, and plasma coagulator. The new descriptor for control of bleeding replaces all examples with "any method." Moreover, if the GI applies a submucosal injection as part of the control of bleeding procedure, then you should not report the injection separately.

In this case, you should only bill 45334, which bundles the work described by another sigmoidoscopy code. You can report 45330 separately only if the gastroenterologist performed the sigmoidoscopy as a standalone, separate procedure and did not provide any service reported by the 45331-45350 code range.

Important: If the GI caused the bleeding during the sigmoidoscopy and then had to control it, you can only report 45330 or the procedure code that caused the bleeding (45331, 45338, etc.), and not 45334.

Tip 3: Get Max Mileage From Sigmoidoscopy + Colonoscopy

Sometimes, a patient may require both a flexible sigmoidoscopy and a colonoscopy through stoma during the same visit to the office. It is not unusual for a GI to perform flexible sigmoidoscopy during the same session as a colonoscopy through stoma. This can happen when the patient has had a prior surgery that required a temporary colostomy.

"In many cases the colostomy was performed emergently for acute diverticulitis or because of an obstructing cancer. The entire colon was not examined either before surgery or immediately afterward so, before repairing the colon, the surgeon will often require a thorough examination of the colon above the colostomy opening and then for the distal colon from the anus up to the diversion," adds **Weinstein**.

In this instance, you can safely report code 44388 (Colonoscopy through stoma; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) and 45330. You should also add modifier 59 (Distinct procedural service).

$$$ factor: As 44388 and 45330 belong to the different endoscopic family of codes, you can recoup 100 percent of the allowable fee for the colonoscopy, which comes out to be $359.69 (10.06 RVUs multiplied by 2015 conversion factor of 35.7547).You will also get paid 50 percent of the allowable fee for the flexible sigmoidoscopy ($139.80, [3.91 RVUs multiplied by 2015 conversion factor of 35.7547]), which amounts to $69.90. As sigmoidoscopy is the lesser paying procedure, you should attach modifier 59 to 45330.