Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Answer 3 Questions to Ace Your Upper GI EUS Claims

Report the EGD EUS only if your gastroenterologist has documented this procedure.

Do you automatically reach for endoscopic codes whenever your gastroenterologist uses endoscopic ultrasound (EUS) for any structural evaluation of the luminal wall and adjacent tissues in the gastrointestinal tract? Then you're heading for trouble as EUS has its own specific codes. Answer these questions such as the extent of EUS, presence or absence of biopsy to get the max out of EUS procedures.

1. What is the Extent of GI Tract Examination?

When your gastroenterologist performs an EUS on the esophagus, the most important consideration is the extent to which the scope advanced during the examination.

EUS limited to the esophagus: The gastroenterologist may have planned upon a full esophagogastroduodenoscopy (EGD) but may be forced to restrict the use of EUS to the esophagus if he encounters a stricture preventing the progress of the scope to the stomach (e.g., in case of esophageal or mediastinum tumors).

For example: Your gastroenterologist decides to undertake an EGD for a patient with severe heartburn and chest pain symptoms. However, as he passes the endoscope over tongue and after entering the esophagus, he notes marked edema and two tumors in the lower esophagus. The physician is unable to pass this area through the lower esophageal sphincter. Only the esophagus is visualized and the physician performs a EUS to study the tumors.

In such a case where the physician only examines the esophageal region with EUS, you should report 43231 (Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination)," informs **Michael Weinstein, MD,** Vice President of Capital Digestive Care.

Caution: You should code 43231 only once even if the physician examines multiple tumors in a single session.

Esophageal limited EUS with EGD: A second scenario may involve the physician being able to fully examine the esophagus, stomach, and either the duodenum and/or jejunum but only a limited examination of the esophagus using EUS.

Example: Extending the above example, after performing an EUS for the esophagus, your gastroenterologist may then decide to perform a thorough upper endoscopy (EGD) to examine the other parts of the stomach, the duodenum, and the jejunum to see if there are any other tumors.

Here, you would report the procedure with CPT® code 43237 (Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures). The code clarifies that although the GI used the ultrasound only in the esophagus, he carried out a thorough examination of the stomach, duodenum and adjacent structures with the endoscope.

Full EUS with EGD: In many circumstances, the gastroenterologist may go for EUS all the way beyond the stomach to the small intestine. Compelling reasons that require an EUS past the esophagus may include tumors, gastric ulcers duodenal masses, strictures, pancreatic mass, pancreatic pseudocyst, or ampullary (major papilla) masses.

If the gastroenterologist is investigating a gastric ulcerating mass and performs an EGD using EUS on the gastric mass and proximal duodenum, you should report the service with 43259 (Esophagogastroduodenoscopy, flexible, transoral;

with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis).

How to know the difference: You are safe with the esophagoscopy code (43231) if the scope doesn't go past the esophagus. If the documentation states that the scope reached the pyloric channel, your claim for an esophagoscopy converts into an EGD/EUS claim. However, report the EGD EUS only if your gastroenterologist has documented the clear reason for examining the stomach, duodenum, liver, adrenal gland or pancreas with an ultrasound.

2. Was There a Biopsy Involved With the EUS?

In some cases, your gastroenterologist may decide to conduct a biopsy of the mass that he has inspected during EUS. For the biopsy, he will perform a fine needle aspiration (FNA) with EUS. This is used to aspirate or biopsy a mass of the esophagus that is suspicious for malignancy (for instance, pancreatic pseudocysts or submucosal masses in the stomach). CPT® has provided each of the EUS codes with a corresponding FNA code that you can report for this extended service.

In case of an esophagoscopy with FNA, you should report code 43232 (Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy[s]). If the physician conducts a fine needle aspiration/biopsy while doing an EGD where the EUS is limited to the esophagus, you should opt for code 43238 (Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy[s], [includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures]).

However, if your gastroenterologist documents the extension of the endoscope (with EUS) beyond the esophagus for biopsy, then you need to switch to 43242 (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 examined distal to the anastomosis]).

Stop: As the EUS with FNA codes include the EUS service, do not report 43238 and 43237 together. Same is applicable for code pair 43242 and 43259 as well as 43231 and 43232. Moreover, as the code descriptor states "biopsy(s)," you will report the biopsy code only once even for multiple biopsies in the same session.

3. Have You Fulfilled the EUS Documentation And Diagnosis Conditions?

Documentation is pivotal for optimizing your billing for EUS and for assigning the correct codes. Therefore, you should check your local payer's documentation requirements and coordinate them with your physicians to ensure maximum reimbursement along with correct coding. For example, if you are still unsure of the exact location and/or the extent of the EUS procedure after reading the operative report, your best course would be to query the physician to avoid future embarrassment.

For example: If your physician takes an EUS-guided esophageal biopsy, but you fail to note that he completes an endoscopy thorough the duodenum or jejunum, you might choose 43232 (6.05 facility RVUs multiplied by 2015 conversion factor 35.7547 = $216.32) instead of 43238 (7.14 facility RVUs multiplied by 2015 conversion factor 35.7547 = $255.29) and lose valuable dollars $39 to be precise.

Even worse, if the GI documents an upper GI endoscopy with EUS examination of the esophagus, stomach, and the duodenum, but takes a biopsy from the esophagus, you might erroneously code 43238 (7.14 facility RVUs multiplied by 2015 conversion factor 35.7547 = $255.29) instead of 43242 (8.05 facility RVUs multiplied by 2015 conversion factor 35.7547 = $287.83), a loss of $32.

Also, the physician needs to be sufficiently detailed in his procedure notes to justify the decisions he took during the procedure and to pass any post-claim audit. For example, if an esophagoscopy becomes an EGD EUS (43259 or 43237), your gastroenterologist must have a documented reason for examining the stomach, duodenum, liver, adrenal gland or pancreas. Even though the instrument can be passed lower, there should be necessary indication to use the ultrasound

beyond the esophagus.

Be sure to be on the right side of your payer's acceptable diagnosis codes and requirements for EUS when the claim goes up for reimbursement. For example, some of the codes not accepted by Aetna include:

- 196.0 - 196.9 -- Secondary and unspecified malignant neoplasm of lymph nodes [for differential diagnosis of malignant lymph nodes] {ICD-10 crossover: C77.x}
- 197.8 -- Secondary malignant neoplasm of other digestive organs and spleen [for differentiation of benign and malignant pancreatic masses]{ICD-10 crossover: C78.7}
- 211.6 -- Benign neoplasm of pancreas except Islets of Langerhans [for differentiation of benign and malignant pancreatic masses]{ICD-10 crossover: D13.6}
- 239.0 -- Neoplasm of unspecified nature of digestive system [for differentiation of benign and malignant pancreatic masses]{ICD-10 crossover: D49.0}, etc.

Aetna also considers the EUS procedure as experimental and investigational for conditions such as EUS-elastography (for differentiation of benign and malignant pancreatic masses; differential diagnosis of malignant lymph nodes) or for staging of tumors shown to be metastatic by other imaging methods (unless the results are the basis for therapeutic decisions). Refer to URL: http://www.aetna.com/cpb/medical/data/400_499/0446.html