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Outpatient Facility Coding Alert

CPT® 2014: Prepare Now for Changes to ENT Related Endoscopies

Hint: You'll add 8 new codes to your repertoire.

If ENTs perform endoscopies or esophagoscopies at your facility, don't miss some changes to codes and guidelines that will affect your coding in 2014. Richard W. Waguespack, MD, a member of the CPT® Advisory Committee, shared details from three important areas during the AMA's annual CPT® and RBRVS Symposium in Chicago Nov. 13-15.

1. Get Familiar With Additional Guidelines

The entire Esophagus/Endoscopy section has been divided into three subsections for 2014: esophagoscopy, esophagogastroduodenoscopy (EGD), and endoscopic retrograde cholangiopancreatography (ERCP). Three new coding guidelines apply specifically to the entire section:

- Surgical endoscopy always includes diagnostic endoscopy.
- Control of bleeding that occurs as a result of the endoscopic procedure is not separately reported during the same operative session.
- Esophagoscopy includes examination from the cricopharyngeus muscle (upper esophageal sphincter) to and including the gastroesophageal junction. It may also include examination of the proximal region of the stomach via retroflexion when performed.

2. Get Familiar With New Codes

CPT® 2014 introduces six new codes for rigid esophagoscopy and two new codes for transnasal flexible esophagoscopy.

Prior to 2014, you had a group of codes that applied to either rigid or flexible transoral esophagoscopy (43200-43232).

Reasoning: "The need for distinction between rigid and flexible esophagoscopy lies in the fact that different means of sedation are used for each and the physician work including risk is different," Waguespack shared at the Symposium. For example:

- Transoral rigid esophagoscopies are typically performed under general anesthesia.
- Transoral flexible normally are performed under moderate sedation.
- Transnasal flexible procedures typically use topical anesthesia. Transnasal flexible esophagoscopies are often performed in the office.

The new codes for rigid esophagoscopy are:

- 43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)
- 43192 ... with directed submucosal injection(s), any substance
- 43193 ... with biopsy, single or multiple
- 43194 ... with removal of foreign body
- 43195 ... with balloon dilation (less than 30 mm diameter)
- 43196 ... with insertion of guide wire followed by dilation over guide wire.

Pay attention: Each new code also includes parenthetical notes to help you report the service correctly.

Transnasal flexible esophagoscopy (TNE) earned two new codes because the work involved in performing TNE differs from the transoral rigid or flexible approaches. The two new codes for 2014 are:

- 43197 – Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing when performed (separate procedure)
- 43198 – ... with biopsy, single or multiple.

Parenthetical instructions list numerous codes you should not submit with either 43197 or 43198. You're also directed to a different code family when reporting transoral esophagoscopy with biopsy or collection of specimen.

3. Keep Tabs on Details for Nasal Sinus Endoscopy

Waguespack shared that code 31237 (Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement [separate procedure]) was identified through the CMS High Expenditure Procedural Codes screen. The RUC has recommended a survey of physician work and review of practice expense for this code group of services. The group being studied includes 31237 as well as:

- 31238 – ... with control of nasal hemorrhage
- 31239 – ... with dacryocystorhinostomy
- 31240 – ... with concha bullosa resection.

Background: Surgeons perform follow-up debridement (31237) after virtually every endoscopic sinus surgery case. Patients typically have about three debridement sessions, but no official guidelines outlining a standard number of treatments exist. Placing 31237 on a "watch list" means that surgeons should become more conscientious of how often they're performing and billing for the service post-surgery.