Outpatient Facility Coding Alert

CPT® Coding: Break Down the Nuances of This EGD, Colonoscopy Example

Note when the surgery changes from diagnostic scope to surgical endoscopy.

When you're tasked with coding a surgery involving multiple endoscopies, you've got to know exactly what elements to consider in order to uncover the correct set of codes. That involves properly evaluating the specimen excisions and factoring in bundling edits.

Use the following case as a reference and check out some expert analysis of how to get to the bottom of the correct CPT® and ICD-10-CM code assignments.

Appraise the Case

The surgeon performed a colonoscopy and an esophagogastroduodenoscopy (EGD) for a patient with severe iron-deficiency anemia to rule out internal bleeding and malabsorption in the gastrointestinal (GI) tract. The surgeon noted a large hiatal hernia with bleeding and linear lesions at the neck of the hernia.

Specimens: The surgeon submits the following specimens for pathology:

A. Z-line biopsy: 8 mm erythematous, eroded mucosal tissue from gastroesophageal junction.
B. Duodenum biopsy with mild inflammation.
C. Polyp from ascending colon.

Diagnosis: The pathology report documents the following for each specimen:

A. Noted histopathologic changes of interstitial congestion and mucosal degeneration consistent with ischemia: diagnosis Cameron erosions.
B. Visualized five elongated villi with submucosal Brunner's glands. Villous to crypt ratio 4:1, PAS stain negative: diagnosis normal duodenal tissue.
C. For 1.3 cm polyp, noted low grade dysplasia, 20 percent villous component: diagnosis tubular adenoma.

Assign Scope Procedure Codes

"Because the surgeon performed two different endoscopic procedures, you'll need to code each separately," says **Terri Brame Joy, MBA, CPC, COC, CGSC, CPC-I**, vice president for revenue management with Encounter Telehealth in Omaha, Nebr.

EGD: During the EGD procedure, the surgeon documented taking a biopsy from the gastroesophageal junction, and a biopsy from the duodenum. The correct code for the procedure is 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple).

Break it down: The following three factors impact your code choice:

- Although the surgeon may have initiated the procedure as a diagnostic scope to visualize the upper GI tract, the procedure becomes a surgical endoscopy when the surgeon performs additional work, such as taking a biopsy. For coding purposes, surgical endoscopy always includes diagnostic endoscopy, so you should code just the most extensive surgical procedure (43239) instead of (not in addition to) the diagnostic procedure (43235, ... diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate

procedure))

- The surgeon provides no documentation of ultrasound examination or guidance, or other procedures such as balloon dilation, so you should turn away from any of the codes in the EGD section (43236-43270) that involve procedures other than biopsy.
- Despite taking two biopsy specimens, you should report only one unit of 43239. The code definition states "biopsy, single or multiple," so you should report just one unit of the EGD code regardless of the number of biopsies involved.

Colonoscopy: For the colonoscopy, you should report 45385 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique). Just like the EGD, performing a polypectomy means that this is a surgical colonoscopy, so you shouldn't additionally code the diagnostic colonoscopy (45378, … diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)). You should also eschew other codes in the colonoscopy section (45378-45398) for other procedures that the surgeon doesn't document.

Avoid ICD-10 Specimen Traps

Assigning ICD-10-CM codes for this case can be tricky, with several potential pitfalls you need to avoid.

EGD specimens: The Z-line biopsy and duodenum biopsy are from the EGD procedure, and you can assign an ICD-10 code for each specimen.

Trap 1: Specimen A is from the gastroesophageal junction, and the pathologic description is consistent with gastric ischemic gastritis, which would lead to different coding.

Key: The surgeon's documentation of a large hiatal hernia associated with linear lesions, coupled with the microscopic evidence led the pathologist to diagnose Cameron erosions, which are a type of gastric ulcer. That diagnosis is also consistent with the pre-op diagnosis of severe anemia. Assign diagnosis code K25.4 (Chronic or unspecified gastric ulcer with hemorrhage).

Specimen B is a duodenum biopsy demonstrating mild inflammation, which codes to K52.9 (Noninfective gastroenteritis and colitis, unspecified).

Colonoscopy specimens: The colonic polyp specimen is from the colonoscopy procedure.

Trap 2: The pathologist's diagnosis for the colonic polyp is tubular adenoma. But if you choose K63.5 (Polyp of colon) for the diagnosis code, you will be wrong. Looking at the Excludes1 note under K63.5, you'll see that the code does not describe an adenomatous polyp. Tubular adenoma is an adenomatous polyp, so you should report the diagnosis as D12.6 (Benign neoplasm of colon, unspecified).

Final Tally

Your final procedure coding for the case should be 45385 for the colonoscopy with polypectomy and 43239 for the EGD with biopsies. "These codes represent two distinct procedures at different anatomic sites, and CCI doesn't bundle the codes, so you can report them together without modifier or restriction," Joy says.

The final diagnosis codes are K25.4, K52.9, and D12.6. Both the Cameron erosions and polyp diagnoses will impact treatment and follow-up regimens for this patient.