Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Don't Code Service to Fix Problem Caused By the Physician

Question: My doctor attempted to do a banding of esophageal varices. He could not put the bands on, but in the process caused active variceal bleeding. He treated the bleeding with sclerotherapy. Should I report the banding of the esophageal varices, the sclerotherapy, or both?

Missouri Subscriber

Answer: Report 43244 (Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices) with modifier 53 (Discontinued procedure). Be sure to include a copy of the operative report with the claim so the payer can understand why the gastroenterologist discontinued the procedure. In the facility setting you would report modifier -73 (Discontinued Out-Patient Hospital/Ambulatory Surgery Center [ASC] Procedure Prior to the Administration of Anesthesia) or -74 (...After Administration of Anesthesia), depending upon the circumstances. You should get some reimbursement for the service, but the amount will probably vary from payer to payer.

You cannot bill for the sclerotherapy (43243, ... with injection sclerosis of esophageal / gastric varices) because Medicare and most private insurers have a you-break-it-you-fix-it policy. For the same reason, you should not also bill for the control of bleeding (43255, ... with control of bleeding, any method).

When a complication described by codes defining complications arises during an operative session, however, you should not report a separate service for treating such complications, states the National Correct Coding Policy Manual for Medicare Part B Carriers (also known as the Correct Coding Initiative).