Outpatient Facility Coding Alert

Upper GI Update: Follow These Tips for Successful Reimbursement of Scope Procedures

Pay attention to the documentation when endoscopy crosses the proximal duodenum.

You have to walk a fine line when billing for scope procedures, especially when your physician takes the endoscope past beyond the proximal duodenum. Do you report an esophagogastroduodenoscopy (EGD) or a push enteroscopy? Finding the correct answer to this question will save you hours of frustration and lost dollars. Keep these expert tips in mind to avoid unnecessary appeals and rejections.

Clarify Your Scope Code Confusion

Before coding the scope, first follow this basic checklist:

Scope limited to esophagus: Choose from esophagoscopy codes 43180-43233 to report an endoscopic examination of the esophagus even if the gastroenterologist incidentally enters the stomach, as may happen if the physician needs to gain a retroflex view back at the cardia. Code options include those emanating from parent codes 43191 (Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen[s] by brushing or washing when performed [separate procedure]) and 43200 (Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed [separate procedure]).

Scope limited up to duodenum: Go for EGD codes 43235-43259, such as base EGD code 43235 (Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]), when your gastroenterologist passes the pylorus with the endoscope. Even if the physician passes the pylorus and enters the jejunum due to an altered anatomy such as a Billroth II to examine the upper GI tract or after bariatric surgery, you should choose a code from the 43235 EGD series.

Scope passes second portion of duodenum: You can code for enteroscopy (44360-44379), such as base code 44360 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]) once the scope passes the second portion of the duodenum. To appropriately report codes from the 44360 series, you have to have medical necessity to examine the jejunum. The physician typically accesses well beyond the ligament of Treitz area and well into the jejunum.

Dig Into Documentation for Endoscopy Focus:

Patient charts and op notes are your closest allies for correctly assessing your physician's scope and intention of endoscopy.

Focus on this: You should only report what your physician has stated as his focus or intention for the scope examination. Occasionally, a physician, for erring on the side of caution, may take a quick look past the duodenum through the scope. However, you should steer clear of coding this as 44361 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple) if the physician's documentation doesn't show that there's a medically necessary reason. Even the prior patient chart notes must support the gastroenterologist's reason for going that far.

Usually, the physician will document that his "intent" is to do an EGD. Clinically, he is just being thorough when he goes "beyond the second portion of the duodenum." This becomes a problem when you code all EGDs that document "beyond the second portion of the duodenum" as enteroscopies. Keep a check, because if the physician performs enteroscopy, he will document that and will only be looking in the small bowel.

"In most cases, the procedure will be scheduled as a 'push enteroscopy' and the instrument used for the procedure will be a pediatric colonoscope or a long enteroscope and it will not be the standard upper endoscope," informs **Michael Weinstein, MD,** vice president of Capital Digestive Care, Washington DC.

The American Society for Gastrointestinal Endoscopy (ASGE) Coding Primer: A Guide for Gastroenterologists states, "If an endoscope happens to be passed into the proximal jejunum during a routine upper endoscopy due to a short duodenum or altered anatomy it does not automatically enable the use of these codes."

Obey Edit Limitations

For a single procedure, you need to pick the most appropriate code from the 43235 or 44360 family. Be familiar with the Correct Coding Initiative (CCI) edits, which do not allow payment for the base EGD code (43235) with the enteroscopy code (44360) because the standard endoscopy procedure is included in the enteroscopy code by definition.

You should also avoid coding together two codes from the same family -- CCI bundles 43235 with codes such as 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple) and 44360 with 44361 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple). That's because the CPT® guidelines state that surgical/therapeutic endoscopy always includes diagnostic endoscopy.

Exception: However, in some cases there is "1" modifier indicator with the CCI edits that allow the use of otherwise bundled codes under unusual circumstances. If two different instruments were needed for two different indications then it may be possible to bypass the edit with modifier 59 (Distinct procedural service) or one of the new X{EPSU} modifiers, by providing the appropriate documentation.

Place of Service Makes a Difference

A more extensive procedure does not always translate into more dollars. The place of service is a key factor in determining the endoscopy payment you recoup. Even though push enteroscopy goes deeper, and you may think you would always get paid more for that procedure versus the EGD, it is not so.

Reasoning: The AMA considers an upper endoscopy with biopsy safe to perform in the office. Therefore, your gastroenterologist may perform the procedure in a "non-facility" setting. Since, there is a significant additional practice expense payment for 43239, you'll actually earn more for the EGD in the office than you earn for the push enteroscopy -- which can only be performed in a facility setting -- even though the push enteroscopy goes farther.

The difference: CMS assigns 4.91 relative value units (RVUs) for 44361 in the facility setting. Code 43239 has only 4.29 RVUs in a facility setting but 11.48 in a non-facility setting (based on the 2015 Medicare Physician Fee Schedule, which pays 35.9335 per RVU).