Expect systematic digestive tract changes.

Forewarned is forearmed, so let us take you on a whirlwind tour of what you can expect from 2015 coding changes for your general surgery practice.

With more than 70 code additions, deletions, and revisions that your surgeon is likely to use, you can’t afford to wait until next January to get to know the code changes.

Engage New and Updated Digestive System Codes

The largest number of code revisions and additions you’ll find in CPT® 2015 for your general surgery group comes from the endoscopy codes. “Expect changes from esophagoscopy, to esophagogastroduodenoscopy, to sigmoidoscopy, to colonoscopy, and finally, anoscopy.

Standardize wording: The endoscopy code revisions impart uniformity from one section to another, for instance, changing “with removal of foreign body” to “with removal of foreign body(s)” in all the relevant codes. CPT® 2015 also clarifies the language “including collection of specimen(s) by brushing or washing, when performed” in many endoscopy code definitions.

Expand stent placement, lesion ablation options: Also consistent from small intestine to colon, CPT® 2015 deletes codes for transendoscopic stent placement and lesion ablation, such as 45339 (Sigmoidoscopy, flexible; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) and 45345 (… with transendoscopic stent placement [includes predilation]).

In place of the deleted codes, CPT® 2015 adds new codes that standardize the code descriptors and are part of a larger group that defines various additional services. For instance, instead of 45339 or 45345, you’ll have the following codes to choose from, beginning Jan. 1, 2015:

- 45346 — Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
- 45347 — … with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
- 45349 — … with endoscopic mucosal resection
- 45350 — … with band ligation(s) (e.g., hemorrhoids).

Change Category III codes: Beginning Jan. 1, you’ll have two new anoscopy codes that replace two Category III codes that CPT® 2015 deletes:

- 46601 — Anoscopy; diagnostic, with high-resolution magnification (HRA) (e.g., colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
- 46607 — …with high-resolution magnification (HRA) (e.g., colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple.

The deleted Category III codes are as follows:
• 0226T — Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed
• 0227T — ... with biopsy(ies).

Clip and Save for 2015 Reference

For looking ahead now and for looking back once 2015 rolls in, we’ve created a handy reference tool in the following chart. The table below condenses the most significant CPT® 2015 changes for general surgery coders into one place:

CPT® 2015: Prepare Now for Esophagoscopy Code Changes in 2015

Plus: Don’t miss the new codes for chronic care management services.

The American Medical Association (AMA) has released its initial list of CPT® code updates for 2015, and several apply specifically otolaryngology practices. Read on for details on how your esophagoscopy coding will change starting Jan. 1, and get the lowdown on other additions, revisions, and deletions for your practice.

Look How Esophagoscopy Codes Will Include More Services

Your biggest procedure coding changes will be related to esophagoscopy. CPT® 2015 will include one new code, as well as revisions to six others.

New option: The new code will be 43180 (Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker’s diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed).

Important: Codes 43215, 43216, 43247, and 43250 include a “bulls-eye” designation. That means the valuation of the code already includes moderate sedation. Therefore, you wouldn’t report a moderate sedation code such as 99143 (Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports,
requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time) with any of these procedures.

Eliminate 3 Eustachian Tube Procedure Options

Three codes for procedures related to Eustachian tube inflation and/or catheterization will no longer be valid, beginning Jan. 1, 2015. They are:

- 69400 – Eustachian tube inflation, transnasal; with catheterization
- 69401 – ... without catheterization
- 69405 – Eustachian tube catheterization; transtympanic.

Check When Chronic Care Management Might Apply

CPT® 2013 introduced three new codes for complex chronic care coordination services (99487, 99498, and +99489). CPT® 2015 expands on this concept by adding two codes for chronic care management services:

- 99490 – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
  - chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - comprehensive care plan established, implemented, revised, or monitored.
- +99498 – ... each additional 30 minutes (List separately in addition to code for primary procedure).

Specialists such as pain management, oncology, or family practice physicians probably will use these codes most often. An otolaryngologist might have need for them in special circumstances, however, which is why it’s good to be aware of the options.

CPT® 2015: New Lower GI Endoscopy Changes Echo the Upper GI Endoscopy Changes From Last Year

You’ll reduce the amount of times you use modifier 52 for GI procedures.

If you want to avoid headaches starting in the New Year, then you need to immerse yourself in the significant changes to coding for lower GI endoscopic procedures in CPT® 2015. These changes are consistent with similar changes made to upper GI endoscopy codes in CPT® 2014. These revisions also conclude a concerted effort to standardize the terminology of the GI endoscopy codes.

Descriptor Edits Changes the Way You Will Report GI Procedures

The CPT® Editorial Panel continues to standardize the language and make the code descriptors more accurate in lower GI endoscopy procedures. This will affect codes across the lower GI spectrum with changes in:

Base codes: The panel has continued with the standardization of the code descriptor by replacing the terminology “with or without” in the codes with “including, when performed.” This is similar to what was done to upper GI procedures (see “CPT® 2015 Part 1: Non-Inclusive Diverticulitis Drives New Esophagoscopy Changes” featured in the Gastroenterology Coding Alert volume 16 number 11). This particular change is applicable for the base codes of endoscopy families.
January onward, you will have to use codes for unlisted procedures to report use of bipolar cautery.

- Bipolar cautery: removal by hot biopsy forceps, bipolar cautery or snare technique (polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique performed).
- Stoma; with ablation of tumor[s], polyp[s], or other lesion[s] (includes pre- and post-dilation and guide wire passage, when performed (separate procedure)).

Similarly, code 44380 will read as “Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)”

- Code 44385 will be described as “Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)”
- Code 44388 for stomal colonoscopy will now read as “Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)”
- Code 45330 updates to “Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)”
- Code 45378 will read as “Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).”
- Code 45337 will replace 45335 with “Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)”
- Code 45330 replaces 45335 with “Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)”

Keep in mind that the changes in descriptor language do not affect the usage the above codes in any way. The changes are just a continuation in standardization of the language.

**Foreign body removal:** You also have to implement descriptor changes for removal of foreign body, which effectively specifies that from next year onward, you will be reporting foreign body removal only once even if the physician removed multiple bodies in the same session. Code 45332 will change to “Sigmoidoscopy, flexible; with removal of foreign body[s].” Similar changes will affect 44363 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)), 44390 (Colonoscopy through stoma; with removal of foreign body(s)), and 45379 (Colonoscopy, flexible; with removal of foreign body(s)).

**Control of bleeding:** The panel has replaced all previous code descriptors for control of bleeding codes (such as injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, and plasma coagulator) with a single term “any method.” For example, 44391 will change to “Colonoscopy through stoma; with control of bleeding, any method.” Similarly updated codes are 45334 (Sigmoidoscopy, flexible; with control of bleeding, any method) and 45382 (Colonoscopy; with control of bleeding, any method).

**Stent placement:** The new lower GI endoscopy codes for placement of endoscopic stents will now include pre-dilation, post-dilation and guide wire passage, whereas you currently consider only pre-dilation. You will not report modifier 52 (Reduced services), even if the GI does not perform all the three components during the same session and you will not be allowed to report these separately also. All old stent related codes stand deleted and new codes reflecting the change have been introduced instead. For instance, CPT® deletes 44383 and replaces it with new code 44384 (Ileoscopy, through stoma; with placement of endoscopic stent [includes pre- and post-dilation and guide wire passage, when performed]) takes its place. Similarly, 44402 will replace 44397 (Colonoscopy through stoma; with transendoscopic stent placement [includes predilation]); 45347 will replace 45345 (Sigmoidoscopy, flexible; with transendoscopic stent placement [includes predilation]); and new code 45389 replaces 45387 (Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement [includes predilation])

**Ablation:** New codes for ablation procedures follow the same changes done to stent procedures and will include pre- and post-dilation and guide wire passage, when performed. Separate reporting of pre- or post-dilation or guide wire passage will be rejected due to bundling. For instance, you will delete 44393, and you’ll add new code 44401 (Colonoscopy through stoma; with ablation of tumor[s], polyp[s], or other lesion[s] [includes pre- and post-dilation and guide wire passage, when performed]). Similarly, new codes 45346 and 45388 replace 45339 (Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) and 45383 (Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) respectively.

**Bipolar cautery:** CPT® 2015 has also modified tumor removal codes by taking out the reference to “bipolar cautery.” For example, 44392 will become “Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps” in accordance with the latest techniques being used for growth removal. Similar modifications can be seen to 45333 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps) and 45384 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps). Therefore, from January onward, you will have to use codes for unlisted procedures to report use of bipolar cautery.
New Introductions in Colonoscopy Codes Expands the Family

The CPT® Editorial Panel has now defined colonoscopy as the examination of the whole colon because CPT® 2015 removes the phrase “proximal to splenic flexure” from the official descriptor for code 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression [separate procedure]), which indicates the procedure applies to the entire colon, rather than just a specific portion.

Other than changing the descriptors of the existing codes, CPT® 2015 introduces new codes for transendoscopic balloon dilation and endoscopic mucosal resection. So, if your physician performs a simple endoscopy and has to use balloon dilation for the simple purpose of better visualization, you will be able to report this new code 44381 (Ileoscopy, through stoma; with transendoscopic balloon dilation). CPT® 2015 has introduced a similar code for colonoscopy 44405 (Colonoscopy through stoma; with transendoscopic balloon dilation).

Get ready for new codes describing endoscopic mucosal resection (EMR) including injection-assisted, cap-assisted, and ligation-assisted techniques. CPT® has now bundled sub-mucosal injection, banding, or snare polypectomy for the same lesion into the code for EMR. Moreover, you will not report a biopsy if your gastroenterologist performs it on the same lesion as the EMR. The new codes are 44403 (Colonoscopy through stoma; with endoscopic mucosal resection), 45349 (Sigmoidoscopy, flexible; with endoscopic mucosal resection), and 45390 (Colonoscopy, flexible; with endoscopic mucosal resection).

Colonoscopy via stoma has been brought at par with flexible colonoscopy with new codes for area-specific ultrasound procedures (with/without fine needle aspiration/biopsy). The new code for colonoscopy via stoma is 44406 (Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures). The corresponding flexible colonoscopy code 45391 has been updated to “…with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures.”

CPT® 2015 has recognized decompression procedures in endoscopies by adding new codes in colonoscopy (flexible and through stoma) and modifying an existing one in sigmoidoscopy. The new codes are 44408 (Colonoscopy through stoma; with decompression [for pathologic distention] [eg, volvulus, megacolon], including placement of decompression tube, when performed) and 45393 (Colonoscopy, flexible; with decompression [for pathologic distention] [eg, volvulus, megacolon], including placement of decompression tube, when performed). The modified sigmoidoscopy code 45337 will be used as “Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed.”

Provision for Unlisted Procedures Keeps Space for Emerging technology

CPT® 2015 has kept a provision for unlisted procedures for procedures not yet coded. You will find that 44799 (Unlisted procedure, small intestine) will now be much more specific with the code being confined to the small intestine. A similar area-specific unlisted procedure has been added with 45399 (Unlisted procedure, colon).

CPT® 2015 37218 Adds Carotid Stent Coding Option

Bundle angioplasty and more to match code revisions.

Both opportunities and restrictions come your way in 2015 for intravascular stent coding, compliments of CPT® 2015 code changes for transcatheter placement codes 37215-37218.

Read on to make sure you’re ready to capture appropriate pay for your general surgeon’s stent placement services, and to avoid coding errors that could lead to costly denials as you implement the new and revised codes.
Distinguish Carotid Artery Site

Stents can go many places in the carotid artery, so you need to know the exact operative site if you want to accurately describe your general surgeon’s work. You currently have three codes to describe carotid artery stenting, the first two of which have revised definitions in CPT® 2015, as follows:

- **37215** — *Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection*
- **37216** — *... without distal embolic protection*
- **61635** — *Transcatheter placement of intravascular stent[s], intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed.*

Codes 37215-37216 describe stent placement in the cervical portion of the extracranial carotid artery. The intended site of these codes is the carotid bifurcation in the neck. On the other hand, you’ll use 61635 for a stent in the intracranial internal carotid artery.

Now CPT® 2015 adds a new code for another carotid artery stent location — the intrathoracic common carotid artery or the innominate artery, specifically with an antegrade surgical approach. The code is **37218** (*Transcatheter placement of intravascular stent[s], intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation*).

**Parallel:** Notice that 37218 is similar to the 2014 code added for retrograde services: **37217** (*Transcatheter placement of an intravascular stent[s], intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation*). Also, CPT® 2015 makes minor revisions to 37217, deleting “an” before “intravascular” and “via” before “open” to standardize the wording of codes 37217 and 37218.

**Clarify What’s Included**

“Existing codes 37215 and 37216 have always included the catheter placement for selective carotid access, and the radiological supervision and interpretation, per CPT® instruction,” says Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, internal audit manager with PeaceHealth in Vancouver, Wash.

Now revisions to 37215 and 37216 in 2015 add language to make this bundling more explicit.

**Don’t miss:** The code revisions also bundle angioplasty with the stent codes, which was not an overt bundling rule prior to the change.

**Open up:** The existing 37215 and 37216 definitions stated that the codes described percutaneous procedures, but the 2015 code revision allows you to use the codes to describe open procedures.
“The changes made to 37215 and 37216 make them more consistent with all other endovascular bundled coding,” says Christy Hembree, CPC, a coder with a private practice in Cartersville, Ga.

**Bottom line:** “These codes now include angioplasty, and supervision and interpretation, and can now be used for open or percutaneous procedures,” Hembree says.

**Study This Clinical Example**

Look at the following example to get a better idea of how you should use the carotid artery stent codes in 2015.

**Case:** Using femoral access and common carotid placement, the surgeon images the right common carotid and right internal carotid. The surgeon documents normal anatomy and states there are no abnormalities in the internal carotid, but she finds stenosis in the cervical common carotid. The surgeon inserts a catheter and places an embolic protection device distal to the stenosis to trap plaque or thrombi. The surgeon advances a stent to the cervical common carotid artery stenosis.

**Solution:** You should report this case using 37215, because the site of the stent is the cervical carotid artery, and the surgeon places a distal embolic protection device.

You should not additionally report 36216 (*Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family*) for placing the catheter in the right carotid artery, because that service is bundled into 37215.

Nor should you separately report 75676 (*Angiography, carotid, cervical, unilateral, radiological supervision and interpretation*), because 37215 states that the code includes “radiological supervision and interpretation.”

**Check out new additions to arthrocentesis procedures that involve guidance**

**Watch Out For Changes to Arthrocentesis Codes**

In the updated CPT® codes in 2015, you will be seeing some changes to the descriptors of codes that you would use to report arthrocentesis. You will also have to take into account some new codes being introduced for these procedures when they involve ultrasound guidance.

The descriptor changes and the new codes that you will see for arthrocentesis include:

- **20600** (*Arthrocentesis, aspiration and/or injection, small joint or bursa [e.g., fingers, toes]; without ultrasound guidance*)
- **20604** (*...with ultrasound guidance, with permanent recording and reporting*)
- **20605** (*Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; without ultrasound guidance*)
- **20606** (*...with ultrasound guidance, with permanent recording and reporting*)
- **20610** (*Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance*)
Coding tip: You will have two different codes for any arthrocentesis procedure depending on whether or not your clinician used ultrasound guidance for placement of the needles in the joint. So, you will have to look at documentation to ascertain the use of ultrasound guidance to arrive at the right CPT® code for the procedure performed.

ICD-10: Consolidate Esophageal Cancer Codes

Look for ‘in situ’ direct crosswalk.

Here’s a rarity for you — you’ll have fewer specific codes to choose from in ICD-10 than ICD-9 — for esophageal cancer, that is.

Although many conditions will have a direct crosswalk or an expansion to numerous, more-specific codes when ICD-10 goes into effect on Oct. 1, 2015, the opposite will happen for malignant esophageal cancer.

Curb Redundancies

In fact, you’ll go from eight ICD-9 codes to five ICD-10 codes for malignant esophageal cancer, as follows:

- 150.0 — Malignant neoplasm of cervical esophagus
- 150.1 — Malignant neoplasm of thoracic esophagus
- 150.2 — Malignant neoplasm of abdominal esophagus
- 150.3 — Malignant neoplasm of upper third of esophagus
- 150.4 — Malignant neoplasm of middle third of esophagus
- 150.5 — Malignant neoplasm of lower third of esophagus
- 150.8 — Malignant neoplasm of other specified part of esophagus
- 150.9 — Malignant neoplasm of esophagus unspecified site
- C15.3 — Malignant neoplasm of upper third of esophagus
- C15.4 — Malignant neoplasm of middle third of esophagus
- C15.5 — Malignant neoplasm of lower third of esophagus
- C15.8 — Malignant neoplasm of overlapping sites of esophagus
- C15.9 — Malignant neoplasm of esophagus, unspecified

Drop terminology: You can see that ICD-10 doesn’t codes that crosswalk from 150.0-150.2. These codes use the “cervical, thoracic, abdominal” terminology, which is repetitive with the codes that distinguish the upper, middle, and lower third of the esophagus.

That means you’ll have a direct crosswalk from 150.3-150.9 to C15.3-C15.9. Although the code definition varies for C15.8, remember that ICD-9 has a text note following 150.8 indicating that the code includes, “Malignant neoplasm of contiguous or overlapping sites of esophagus whose point of origin cannot be determined.”

Match Carcinoma in situ Codes

You can also expect a direct crosswalk for esophageal carcinoma in situ when you change from ICD-9 to ICD-10. Prepare to change from 230.1 (Carcinoma in situ of esophagus) to D00.1 (Carcinoma in situ of esophagus) when ICD-10 goes into effect next fall.

2015 Coding Update: Check Out Your New Alternatives to Modifier 59 in Certain Situations

Modifier 59 is still valid, but use the new modifiers instead when applicable.

While you’re keeping an eye out for coding updates and revisions coming next year, don’t fall in the trap of ignoring modifiers, however, because some big changes are headed your way in 2015.
The scoop: CMS faces multiple issues when dealing with claims reporting modifier 59 (Distinct procedural service). The agency is attempting to solve those issues by introducing four new “X” modifiers that will replace modifier 59 in some instances for claims submitted to CMS. They are:

- **XE:** Separate encounter (A service that is distinct because it occurred during a separate encounter)
- **XS:** Separate structure (A service that is distinct because it was performed on a separate organ/structure)
- **XP:** Separate practitioner (A service that is distinct because it was performed by a different practitioner)
- **XU:** Unusual non-overlapping service (The use of a service that is distinct because it does not overlap usual components of the main service).

CMS announced the change in Transmittal R1422, issued on Aug. 15. Read on for their reasoning and what it might mean for your practice.

**Understand the CMS Perspective**

Modifier 59 can be used to separate CCI (Correct Coding Initiative) edits, but that’s not the only reason it’s available. According to Transmittal R1422, CMS states that many providers misuse modifier 59 for this purpose, leading it to be the source of a projected one-year error rate of $770 million.

CMS points out the following three common reasons that people use modifier 59, along with the associated error odds, according to MLN Matters article MM8863, issued on Aug. 15:

- Infrequently used to identify a separate encounter, typically used correctly
- Less commonly utilized to define a separate anatomic site, less often used correctly
- Commonly used to define a distinct service, but frequently done so incorrectly.

“The 59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place,” the MLN Matters article says. “CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.”

To that end, CMS has debuted the new modifiers, known as the “X(EPSU)” modifiers.

Important: Although the new modifiers will replace modifier 59 in specific instances, CMS won’t cease accepting -59 in 2015. “CMS will not stop recognizing the 59 modifier but notes that CPT® instructions state that the 59 modifier should not be used when a more descriptive modifier is available,” says the Transmittal, which has an effective date of Jan. 1, 2015. “CMS will continue to recognize the 59 modifier in many instances but may selectively require a more specific X(EPSU) modifier for billing certain codes at high risk for incorrect billing.”

Also note: CMS does not want you to play it safe and just add all the modifiers to each CCI edit you’re trying to separate. Therefore, you can’t report both the 59 modifier and an X(EPSU) modifier on the same line item.

See How to Put the X(EPSU) Modifiers Into Practice

**The big picture:**

Having the new modifiers makes you think and make sure you are meeting the definition and not just adding a 59 to get paid because the two codes are bundled. The transmittal said that these new modifiers do not cover all aspects when the 59 might be used so you can still use the 59 modifier if you think it fits the situation better than these four alternatives. However, I think that using the 59 modifier when one of the X codes doesn’t apply may create red flags since there should be few instances when something does not fall under one of these four codes.

**Reader Questions:**

**Use 'Change' Code for Gastrostomy Tube**

**Question:** A patient presented with a partially dislocated gastrostomy tube with pain at the site. The surgeon enlarged the skin opening and attempted unsuccessfully to remove the gastrostomy tube. After further enlarging the opening, the op note states that the surgeon “could feel the flange with the clamp and grasp it and fold it up into the wound, allowing the remainder of the flange to collapse and the tube to be removed.” The surgeon then placed a new tube at the site. How should we code the procedure?
Answer: The correct code for this service is 43760 (Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance).

Despite initial difficulty, the op note indicates that the dislocated tube was successfully removed using traction to pull the tube out. Because the dislodged tube is removed and a new tube placed through the established tract without fluoroscopic guidance or endoscopy, 43760 is the most accurate code for the service.

With adequate documentation, you may be able to report this service with modifier 22 (Increased procedural services).

Options: If the surgeon had used a fluoroscopic aid to guide the G-tube change, instead of 43760, you would select 49450 (Replacement of gastrostomy or cecostomy [or other colonic] tube, percutaneous, under fluoroscopic guidance including contrast injection[s], image documentation and report). If your surgeon performed a reinsertion or replacement of a gastrostomy tube using endoscopic guidance, there is not a distinct CPT® code for the service. In such a case, you would have to report the same CPT® code that you would use for the initial gastrostomy tube placement: 43246 (Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube).

Total Lobectomy Follows Hemithyroidectomy

Question: A patient had a right hemithyroidectomy 2 years ago, but our surgeon claims on the recent surgical note for a new procedure that he performed a total thyroidectomy. The op report states that the surgeon removed the left thyroid, but found a small 2cm x 3cm portion of thyroid gland remaining on the right side, which he dissected off the trachea. How should I code this?

Answer: Your best choice for this scenario would be to report 60220 (Total thyroid lobectomy, unilateral; with or without isthmusectomy) and 60260 (Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid) with modifier 59 (Distinct procedural service). Reporting 60260 should account for the additional work of removing the remaining fraction of the past right hemithyroidectomy.

Although your surgeon may be justified in claiming that this is effectively a total thyroidectomy, the patient’s insurer will probably question paying for 60240 (Thyroidectomy, total or complete) given the patient’s history. Even applying modifier 52 (Reduced services) to 60240 might be problematic with the record of a previous partial thyroidectomy.

Thyroidectomy surgeries can be fraught with reimbursement problems, especially when questions arise about prior surgeries and regrowth on tissue. Aligning the procedure code selection with the patient history should help avoid denials.

Employ These Tools for High-Risk Screening

Question: We had a patient who underwent a “high risk” colonoscopy screening for personal history of colon cancer. The surgeon found no abnormalities and took no biopsies during the procedure, so we billed 45378 with the ordering diagnosis V10.05. However, this payer will only recognize V76.51 for screening colonoscopy, so the patient’s diagnostic benefits were applied, engendering large out-of-pocket expenses. How can we code this scenario to utilize the patient’s screening colonoscopy benefits?

Answer: If you’re billing Medicare, you should report the procedure as a high risk screening with code G0105 (Colorectal cancer screening; colonoscopy on individual at high risk). Then, report V10.05 (Personal history of malignant neoplasm of large intestine) as the primary diagnosis.

Code V10.05 fits the bill for primary diagnosis because the patient presents for a screening exam and not specifically for follow-up evaluation of the cancer. If the encounter’s purpose is for cancer surveillance and follow-up at an interval close to the surgical treatment, you could instead code V67.09 (Follow-up examination following other surgery) as your primary diagnosis although this ICD-9 code is not frequently used.

On the other hand, some commercial carriers would require the code 45378 (Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) with modifier 33 (Preventive services) and V10.05 as the diagnosis.

“CPT® modifier 33 has been created to allow providers to identify to insurance payers and providers that the service was preventive under the applicable laws, and that patient cost-sharing does not apply,” according to AMA. This means that a
patient’s co-insurance, co-payment, and deductible are waived for the applicable services (in this case, 45378). All commercial carriers and Medicare payers should be in compliance with these rules as established in the Accountable Care Act (Obamacare).

List V10.05 as your primary diagnosis for both circumstances (Medicare and commercial payers), whether the colonoscopy findings were clear or not. Don’t report a cancer code (153.3, Malignant neoplasm of sigmoid colon) or the family history code (V16.0, Family history of malignant neoplasm of gastrointestinal tract) or a screening code (V76.51, Special screening for malignant neoplasms colon) as the primary diagnosis in this case.

Choose 'Pexy' Over 'Ectomy'

**Question:** I have a surgical note that states that the surgeon “stapled prolapsed internal hemorrhoids.” Is this 46945, since the hemorrhoids are internal and the surgeon doesn’t use a rubber band?

**Answer:** No, you should not use 46945 (Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group) if the surgeon repairs prolapsed internal hemorrhoids by stapling them.

In fact, the procedure you describe is not a hemorrhoidectomy at all, because the surgeon doesn’t remove the hemorrhoids. Instead, the surgeon repairs the prolapse by stapling the hemorrhoids in the anal canal. This procedure is a hemorrhoidopexy.

The correct code for the procedure is 46947 (Hemorrhoidopexy [e.g., for prolapsing internal hemorrhoids] by stapling). You might see the procedure referred to as Procedure for Prolapse and Hemorrhoids (PPH). In PPH, the surgeon performs a progressive anal dilation and inserts a circular anoscope into the anus, then uses a stapling technique to repair the prolapse.

Surgeons may choose to perform PPH instead of the traditional hemorrhoidectomy, especially if the patient hasn’t responded well to more conservative treatment. There’s some evidence that PPH patients experience fewer adverse effects than those undergoing traditional hemorrhoidectomy, including less intense pain following the procedure.

**Define Date for Global Package**

**Question:** The CPT® surgery guidelines state that the surgical package includes “one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical).” Our question relates to the term “date.” Some in our office think that the term means the calendar date of or preceding the procedure to be bundled. Others in our office think that if there’s a related E/M on any day prior to the procedure (maybe earlier the same week) that it is bundled. Which is correct?

**Answer:** The folks in the office who think the guidelines mean “calendar date” are correct. That’s why the guidelines state “on the date immediately prior to or on the date of procedure.” A day earlier in the same week is not the “date immediately prior.”

**Exception:** Remember that if you have a separate, significant E/M service on the same date as the procedure, you can separately code that service using modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service). For example, the surgeon may identify a previously undiagnosed problem that requires extra evaluation and documentation.

**Distinguish Return to Surgery Modifiers**

**Question:** Our surgeon created an AV access for a dialysis patient, but the patient returned during the global period for a revision due to clotting. How should we bill for declotting the shunt with a balloon catheter, and do we need to use a modifier?

**Answer:** The correct code for the procedure is 36861 (External cannula declotting [separate procedure]; with balloon catheter). Even though the procedure is in the global period, if the patient is returned to surgery, you can bill the CPT® code for the service.

You should append modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) to 36861.
Because the declotting is not a staged procedure (it was not planned), you should not use modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period).

Is E-Mail Ever HIPAA Compliant?

**Question:** We have a consultant who occasionally helps us with billing questions. I’d like to e-mail patient records with my questions, but can I do that without violating HIPAA?

**Answer:** Yes, you can send some patient records via e-mail, but only under very strict guidelines. Under HIPAA’s privacy rule, you should never send protected health information (PHI) via e-mail. But if you remove all individually identifiable health information that reasonably allows individual identification, you should be able to e-mail the clinical facts of the case to your consultant.

**Do this:** Send only the portions of the report that describe the clinical procedure and findings. Plus, include a confidentiality notice at the end of your e-mail. This guideline applies whether you send the e-mail from an office or from home.

**Specifics:** Before you send the report by e-mail, remove the patient’s name and Social Security number. You should also remove geographic identifiers, dates, phone, fax, and e-mail information, and medical record and device serial numbers. Then you read through the report before you send it to be sure you can reasonably assume the patient is no longer identifiable.

Experts advise that for extra security, you send an encrypted email to keep information safe.

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