Billing Diagnosis & Billing in Endoscopy

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2014

Billing Diagnosis

Procedure + E/M on same day

Billing in Endoscopy

BOOKS

- **Federal Register**
  - **RVU table**
  - **Conversion Factor**
- **ICD-9CM**
  - **Regular Codes**
  - **V-Codes: Factors influencing health status and contact with health services (paid only if mandated by law)**
  - **E-Codes: External causes of injury and poisoning**
- **CPT**
  - **E&M**
  - **Anesthesia**
  - **Surgical Procedure**
  - **Radiology**
  - **Pathology & Laboratory**
  - **Medical Procedure**

Billing Diagnosis

Billing Diagnosis

- **Outpatient Visits**:
  - The reason that prompted the visit (sign/symptom/diagnosis)
- **Hospital care**:
  - The final diagnosis;
  - If final diagnosis is not known, then use the reason of the admission (sign/symptom)
- **Diagnostic study/surgery**:
  - **1)** Requires valid indication/reason **(necessity)**
  - **2)** The final diagnosis;
  - 3) If exam is normal, then bill under: Sign or symptom/reason that prompted the study/surgery.

Billing Diagnosis Code

Starting Oct 1st 2014: ICD-10

- Do not code “rule out”, “suspected”, “probable”, “questionable”.
- Must be at the highest level of specificity (XYZ.**AB**)

- Hepatitis X: a) Acute, b) Chronic, c) With hepatic coma
- Ulcerative Colitis: a) Proctitis, b) Proctosigmoiditis, c) Left sided, d) Universal
- Crohn’s: a) Colitis, b) Ileitis, c) Ileo-colitis
- Varices: a) Esophagus, b) Stomach;
  - i)w. bleed ii)w/o bleed
- Ulcer: a) Duodenal, b) Gastric, c) Gastro-jejunal;
  - i) Acute, ii) Chronic
    - j) w. hemorrhage, jj) w. hemorrhage & perforation,
      - k) w/o obstruction, kk) w. obstruction

E&M Service in the same day of a Procedure

Modifier - 25

Significant E&M on "Global Procedure Period": MODIFIER 25

- E&M in day of procedure is for ***"significant, separately identifiable E&M beyond the pre-operative and post-operative work of the procedure"***
- If billing ***"inpatient dialysis code"*** (90935, 90337, 90945, 90947) you must document that ***"service was unrelated and could not be performed during dialysis procedure"***

MODIFIER - 25

- The E&M service may be prompted by the same symptom or condition that prompted the procedure. e.g.: “melena” for
  - Consult level 4 and
  - EGD on same day)
- The same diagnosis can be used for both, E&M and Procedure on the same date.
- The “25 – modifier” is added to the E&M code to “protect it”. (e.g.: 99254-25)

MODIFIER - 25

- E&M visit on the same day of endoscopy or minor surgery (e.g.: cardiac cath) is payable if “significant, and separately identifiable” (separate notes are needed).
- Example: Patient admitted for “Unstable angina”; next day has normal cardiac cath; patient is discharged in view of cath findings: ***Bill for “cardiac cath” and “E&M discharge service” on same day (with 25- modifier for E&M).***

BILLING IN ENDOSCOPY

Service Payment
Total RVU x Conversion Factor

- Total RVU has 3 components:
  - Work RVU considers the effort and training needed to do a service
  - Practice Expense considers the overhead cost of giving the service (low in facility, higher in non-facility)
  - Malpractice RVU covers malpractice costs
- There is other factor that affects the Total RVU; is the Geographic Practice Cost Indices (GPCI).
  - There is a GPCI for each of the 3 components of the RVU.
  - Its function is to incentivize physicians to go to underserved areas.
- **Total Physician RVU is:**
  - [Work RVU x Work GPCI] +
  - [Practice Expense RVU x PE GPCI] +
  - [Malpractice RVU x Malpractice GPCI]

Medicare Conversion Factor

- 1998 36.69
- 2001 37.27
- 2003 36.79
- 2004 37.33
- *2005 37.89*
- ***2006 37.89***
- *2007 37.89*
- *2008 38.08 (peak value)*
- *2009 36.06*
- *2010 36.87*
- *2011 33.97*
- 2012 34.03
- 2013 34.02 (24.84 was proposed)

Billing in Endoscopy

- **Pre-approval required**:
  - Obtain pre-approval for procedure giving clinical information that clearly explains why is needed (ASGE guidelines).
  - Be sure procedure is done within the approved period.
- **No pre-approval required**:
  - Be sure that the indication of the procedure is consistent with ASGE guidelines and
  - Indication is in the list of “IDC-9 which support Medical Necessity” from Medicare Policy.
- If the Indication/Medical Necessity is not valid, **you will not be paid** (Is considered **Fraud**)

Billing for Endoscopy

- Document all what you do:
  - All endoscopic activities (Bx, Hot Bx, Snare, ..)
  - Non-Endoscopic activities (aspiration, pH, lavage, achalasia dilation, Minnesota tube placement,…)
  - Fluoroscopy / Ultrasound w/o radiologist interpretation

  - If you do a ***"significant, separately identifiable "E&M service" beyond the pre-operative and post-operative work of the procedure", add 25 modifier to "E&M service" and bill it.***

Endoscopy Billing

- All **normal diagnostic or screening exams** are billed under:
  - **Primary ICD-9 (until Sept 31) or 10: The indication of the procedure.**
  - Copayments waived for normal "screening procedures"

- All exams with **abnormal** findings *related to the "indication" or which require intervention* (eg. Bx, removal, dilat.) are billed under:
  - **Primary ICD-9: Final diagnosis**
  - **Secondary ICD-9: The indication of the procedure**

Endoscopy Billing

- All exams with **abnormal "incidental" findings not related to the "Indication**/Medical Necessity" are billed under:
  - **Primary IDC-9 or 10: The indication of the procedure.**
  - **Secondary ICD-9 or 10: The incidental finding (s)**

- All **SCREENING** exams with **normal or** only **incidental findings**, should be billed under:
  - **Primary ICD-9: Screening V-code**

Exception to Endoscopy Billing

(MLN Matters # SE0746)

- All **SCREENING** colonoscopy/FS with abnormal **findings that prompt an intervention** (Bx., polypectomy, dilation, …), should be billed as follows:
  - **1) Primary Diagnosis: ICD-9 for the Screening Examination** (V-code) (V76.51 Special Screening malignant Colon neoplasm)
  - **2) Secondary Diagnosis: ICD-9 for the "Final Diagnosis"** (211.3 benign neoplasm of colon).

- The CPT code will be the one for the therapeutic procedure which was done (Not the "Screening" G0105, G0121, nor G0104)
- Copayment will not be waived in this case.

Endoscopy Billing
Extent of Exam – Colon Family

- ***YOU SHOULD ALWAYS DOCUMENT THE MOST DISTANT POINT REACHED.***

- **Colonoscopy:** (45378-45387) Base RVU: F= 6.48; NF= 11.79
  - if the splenic flexure is passed
- **Screening Colonoscopy:** (G0105- high risk & G0121-average risk)
  - if the splenic flexure is passed

- **Sigmoidoscopy:** (45330-45345) Base RVU: F= 1.90; NF= 4.23
  - beyond the rectum and up to the splenic flexure
- **Screening Sigmoidoscopy:** (G0104)
  - beyond the rectum and up to the splenic flexure

- **Proctosigmoidoscopy:** (45300-45305)
  - Rectum + sigmoid only
- **Anoscopy:** (46600-46606)
  - anus only

- **Colonoscopy via stoma** (44388-44397) Base RVU: F= 4.97; NF=10.67

Modifier when “Screening” Service is converted to Diagnostic/Therapeutic Service

- Examples:
  - Screening Colonoscopy (GO105, GO121) is converted to Diagnostic due to biopsy, or Therapeutic due to polypectomy.
  - Screening Flex Sigm (GO104)
- Medicare: Modifier “PT”
  - Screening Colonoscopy + Bx or Polypectomy: GO105-PT; GO121-PT
  - Screening Flex Sigm + Bx: GO104-PT
  - Waives deductible BUT co-pay applies.
- Commercial: Modifier 33
  - Screening Colonoscopy + Bx or polypectomy: 45385-33
  - Screening Flex Sigm + Bx: 45330-33

Modifier for “Incomplete Exam” due to “unforeseen circumstances”

- Incomplete colonoscopy due to “poor prep”; pays as Flex Sigm.
- Preserves the “Screening Benefit”, allowing to perform Screening colonoscopy soon (not waiting 2 years)
- Medicare = 53
  - GO105-53; GO121-53
  - GO104-53
- Commercial = 52
  - 45385-52

Endoscopy Billing
Extent of Exam – EGD Family

- ***YOU SHOULD ALWAYS DOCUMENT THE MOST DISTANT POINT REACHED.***
- **Esophagoscopy:** (43200-43232) Base RVU: F= 3.16; NF= 6.55
  - to E-G junction
- **Esophagus EUS** (44237-44238) Base RVU: F= 6.96; NF= 6.96
- **EGD:** (43235-43259) Base RVU: F= 4.34; NF= 8.9
  - A) esophagus + stomach + duodenum (up to 2nd portion), or jejunum (in gastro-jejunostomy);
  - B) Esophagus & stomach only + maneuver
- **EGD EUS** (43259-) Base RVU: F= 9.03; NF= 9.03
  - EUS codes may be combined with other standard upper or lower endoscopy codes by using the –59 modifier.
  - when a rectal cancer is staged at the time of a colonoscopy, the respective diagnostic or therapeutic colonoscopy codes are used with the –59 modifier but
  - the –52 modifier, to signify an incomplete examination, must be used for the EUS code if the echoendoscope is not used to perform US beyond the splenic flexure.

2014 CPT Code Changes

- ***EGD without duodenum exam:*** *To report esophagogastroscopy where the duodenum is deliberately not examined [e.g., judged clinically not pertinent] or because significant situations preclude such exam [e.g., significant gastric retention precludes safe exam of duodenum], append modifier 52 if repeat examination is not planned or modifier 53 if repeat examination is planned.*
- ***Pseudocyst drainage:*** In addition to transmural drainage of pseudocyst previously described in code 43240, this code has been revised to clarify that the pseudocyst drainage procedure includes performance of endoscopic ultrasound, performance of transmural drainage and placement of stents to facilitate drainage.

Endoscopy Billing
Enteroscopy and ERCP Family

- ***YOU SHOULD ALWAYS DOCUMENT THE MOST DISTANT POINT REACHED.***

- **Enteroscopy without ileum:** (44360-44373) Base RVU: F= 4.69; NF= 4.69
  - beyond 2nd portion of duodenum + "medically indicated"
  - in conjunction with the standard codes for EGD (43235 through 43259) if the EGD is necessary for more than transit to the jejunum or the ileum (eg, biopsy, ablation, polypectomy
- **Enteroscopy including ileum:** (44376-44397). Base RVU: F= 9.05; NF 9.05
  - beyond 2nd portion of duodenum & including ileum
  - in conjunction with the standard codes for EGD (43235 through 43259) if the EGD is necessary for more than transit to the jejunum or the ileum (eg, biopsy, ablation, polypectomy
  - can be combined with the colonoscopy codes (45378 through 45385) if the colonoscopy entailed more than transit to the ileum.

- **Enteroscopy via stoma** (44380-44386) Base RVU: F= 2.03; NF= 2.03

- **ERCP** (43260-43272) Base RVU: F= 10.3; NF= 10.3

Computer Generated Report

- **G-MED**

- Has list of “valid indications”
- Reports all areas not described as: normal.
- Most distant point reached is in “introduction”
- Attending presence chosen at end of report

- **PROVATION**

- You need to know which “indications” are valid.
- Areas not chosen will not be described.
- Most distant point described when you describe the area
- “Attending presence” needs you to close “report flow” and go above.

Endoscopy Billing

- Ask Coder to:
  - "clean out" bundled codes by following the "Correct Coding Initiative-CCI".
  - add all appropriate modifiers according to your documentation.(eg: if you do a polypectomy, and later do hemostasis or biopsy of other lesion, you need a "modifier" to indicate "separate site", meaning that you did not caused the bleed or that you did not Bx the same polyp, and that hemostasis or Bx should be paid)
- **Do not forget to document "Attending Presence" during all viewing part.**
- Appeal all inappropriate rejections.

Payment for Endoscopy

One procedure with several components

- Example: EGD + Savary dilat + Bx + PEG
  - Pays in full highest paying code (EGD+PEG)
  - Pays in addition the “differentials” of all other codes minus the “mother code” (Dx EGD)
    - EGD w PEG, (has highest RVU value) +
    - [EGD w Bx] – [Dx EGD] = A +
    - [EGD w Savary dil.] – [Dx EGD] = B
    - PAYMENT = [**EGD w PEG]** **+ A + B**

Payment for Endoscopy

Several Procedures with Multiple Components

- EGD +PEG + Savary dil + Bx ***plus*** Colonoscopy + Snare polypect + Hot Bx
  - Full amount of highest procedure
    - [Colonoscopy w snare polypect] + [“differential” of Hot Bx] = **A_1**
  - Half of all other procedures:
    - [EGD w PEG] + [“differential” of Savary] + [“differential” of Bx] = **B_1**
  - **PAYMENT = A_1 + ½ B_1**

Payment for Endoscopy

Polypectomy & Lesion-Ablation Techniques

- You are paid by the technique(s) used, and not for the number of polyps/lesions removed.

- **Ablation of Polyp/lesion**
  - 45383= 3.07 over colon RVU (APC, Laser, alcohol injection)
- **Snare Polypectomy (Hot or Cold):**
  - 45385= 2.28 RVU over colon RVU
- **Hot Biopsy or Bipolar Polypectomy:**
  - 45384= 1.41 RVU over colon RVU
- With submucosal "pillow" injection or tattoo:
  - 45381= add 0.49 RVU over polypectomy/ablation
- Polyp removal by Cold Biopsy: is a BIOPSY (NOT POLYPECTOMY): 45380= 1.03 RVU over colon RVU

Payment for Endoscopy

BARRx &
Variceal Banding VS Sclerotherapy VS Hemostasis

- BARRx: Bill as tissue ablation, other technique.

- **<u>VARICEAL TREATMENT</u>**
- If varices were not bleeding and you BAND them:
  - bill for BANDING (43244=3.69 RVU over EGD)
  - Do not use this code for “pre-mucosectomy banding”
- If varices were not bleeding and you do sclerotherapy:
  - bill for SCLEROTHERAPY (43243=3.03 RVU over EGD).
- If varices were bleeding before therapy,
  - bill for “Hemostasis, any method” (43255= 3.24 RVU over EGD) (has lower value than banding)

Payment for Endoscopy
Non-Endoscopic

- Non-Endoscopic “second” procedures done at time of endoscopy are:
  - paid at 50% of their full value (eg: pH, Urease, aspiration, bougie dilation, fluoro, S-B tube, …)
- Third to Fifth procedures are:
  - paid at 25% of their full value

Payment for Endoscopy

Non-Endoscopic

- **DILATION**: You should describe which technique you used (different codes):
  - **Bougie** dilation (43450= 2.08 RVU): (only 1.04 RVU after EGD)
    - Maloney, Hurst, Optical **without guidewire**
  - **Dilation over guidewire before** endoscope passed stricture
    - [usually guidewire placed with fluoro guidance] (43453= 2.08 RVU): Savary, Bard-American, Optical **over guidewire**. (only 1.04 RVU after EGD)
  - **Dilation over guidewire after** endoscope passed stricture
    - (43248= 1.04 RVU over EGD): Savary, Bard-American, Optical **over wire**.
  - **Balloon < 30 mm**
    - (43220=0.44 RVU over EGD)
  - **Balloon =/> 30 mm**
    - Achalasia balloon (43214 for Esophagoscopy or 43233 for EGD (includes fluoroscopy guidance; do not bill fluoro)
  - With FLUOROSCOPY guidance for Dilation (74360= 0.75 RVU); **make 1 picture for documentation.**

Payment for Endoscopy

Non-Endoscopic Component

- **Moderate Sedation/Analgesia**:
  - Is intrinsic part of EGD, ERCP, Enteroscopy, & Colonoscopy;
  - Should be BILL APPART for Flex. Sigm., Liver Bx, Bougie dilation, Paracentesis, etc (99141= 1.23 RVU)
- **Gastric Lavage**:
  - Should be documented and billed; 91105= 0.49 RVU
- **Duodenal Intubation & Aspiration** (with catheter):
  - Should be documented & billed; 89100= 0.85 RVU
- **Mechanical removal of obstructive material from gastrostomy, duodenostomy, or jejunostomy (or other enteric tube) by any method under fluoroscopic guidance.**
  - 49460
- **Gastric Urease Test**: 87077 QW can be billed only if you
  - A) Purchase the “test kit”,
  - B) Read it, and
  - C) Keep a book documenting results **(somewhere in the book should be documentation that you were tested for “color blindness”, and were OK)**

Payment for Endoscopy

Non-Endoscopic Component

- **Gastric pH**:
  - 83986 QW; should be documented in the endoscopy note and billed (your own pH tape).
- **Change of Gastrostomy tube** (non-endoscopic):
  - (43760= 1.64 RVU) should be clearly worded and documented in a note.
- **Replacement of tube percutaneously under fluoroscopic guidance:**
  - Gastrostomy = 49450; Gastrojejunostomy = 49452
- **Minnesota tube placement**:
  - should be clearly documented, and billed (43460= 5.59 RVU) (only 2.8 RVU after EGD)
- **PDT**: total **therapy time** should be documented; billed:
  - initial 30' (96570= 1.52 RVU), and then
  - each additional 15' (96571= 0.77 RVU).
- **Celiac Plexus Block** (under EUS or fluoro guidance):
  - document & bill; (64530= 2.04 RVU)

Payment for Endoscopy

Non-Endoscopic Component

- **Botox for Anal Fissure**:
  - document & bill; (46999= make your charge)
- **Dilation of Rectal Stricture**:
  - document & bill; (45910= 4.06 RVU)
- **Biopsy ano-rectal wall** (non-endoscopic):
  - document & bill; (45100= 6.5 RVU)
- **Banding of Internal Hemorrhoids**: document & bill: (has 90-day global fee)
  - single band (46945= 4.16 RVU);
  - multiple bands (46946= 5.25 RVU) ;

Payment for Endoscopy
Non-Endoscopic Component

- **Optical Endomicroscopy:**
  - Esophagoscopy 43206 = 0 RVU;
  - EGD 43252 = 0 RVU
- **Preparation of fecal microbiota** including assessment of donor specimen 44705 = 1.42 RVU
  - Medicare G0455 = 0.97 RVU, which includes instillation by any method)
  - Instillation of Fecal Microbiota by NGT 44799 (no RVU assigned = 0)

Payment for Endoscopy
Non-Endoscopic Component

- **Wireless Capsule Motility** for pressure and/or transit:
  - 91110 Esophagus to ileum = 3.64 RVU (1.89 Facility or 5.89 Non-Facility);
  - 91111 Esophagus only= 1 RVU (0.52 RVU Facility or 1.56 Non-Facility);
  - 91112 Stomach through colon = 2.1 RVU (1.1 RVU Facility or 3.29 Non-Facility).
- **Neurostimulator pulse generator electronic analysis/reprograming:** 0317T = 0 RVU

Non-Endoscopic Component

Fluoro – U/S guidance (1 hard copy needed)

Description	Code	RVU	Example
F - Dilation	**74360**	**0.75**	Bougie, Savary, Balloon < 3 cm
F - Jejunal tube	**74355**	**1.05**	PEJ
F - PEG/J	**74350**	**1.06**	Conversion PEG to PEG/J
F < than 1 hour	**76000**	**0.25**	Colonoscopy, stent without dilation, Push enteroscopy
F - placement Long GI tube	**74340**	**0.75**	Colon decompression tube, sonde enteroscopy
F - Esophageal Foreign Body Removal	**74235**	**1.65**	Esophageal Foreign body removal
F – Change of PEG WITH CONTRAST	**75984**	**1.0**	Infuse contrast to document changed PEG site.

Non-Endoscopic Component

Fluoro – U/S guidance (1 hard copy needed)

Description	Code	RVU	Example
F – Percutaneous Pseudocyst drainage	**75989**	**1.66**	Endoscopic Drainage of Pseudocyst
F – Biliary ductal S	**74328**	**0.97**	ERC without Radiologist
F – Pancreatic duct	**74329**	**0.97**	ERP without Radiologist
F – Biliary & Pancreatic duct	**74330**	**1.25**	ERCP without Radiologist
F – Liver Bx	**76003**		Liver Bx under Fluoro
U/S – Transrectal Blind Probe	**79872**	**0.96**	Blind Ano-Rectal Probe
U/S - Liver Bx or Paracentesis	**76942**	**0.94**	Liver Bx, Paracentesis without Radiologist

QUESTIONS ?