

Acute Care Surgery Billing, Coding and Documentation Series Part 2: Postoperative Documentation and Coding; Documentation and Coding in Conjunction with Trainees and Advanced Practitioners; Coding Select Procedures

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SUMMARY

This series of reviews has been produced to assist both the experienced surgeon and coder, as well as those just starting practice that may have little formal training in this area. Understanding this complex system will allow the provider to work "smarter, not harder" and garner the maximum compensation for their work. We hope we have been successful in achieving that goal and that this series will provide useful information and be worth the time invested in reading it by bringing tangible benefits to the efficiency of practice and its reimbursement. This second section deals with postoperative documentation and coding, documentation and coding in conjunction with trainees and advanced practitioners, and coding of select procedures.

POSTOPERATIVE CARE DOCUMENTATION, CODING AND EVALUATION AND MANAGEMENT Introduction

It can sometimes be confusing to decide what services can be billed for in the postoperative period. This often results in omission of valid charges and lost revenue. Therefore, it is imperative that the service provider be familiar with what is allowable. Services not covered in the global period of an operation must be recognized and captured to maximize reimbursement.

Many surgeons believe that they are not able to bill for such care in the form of Critical Care Evaluation and Management (E/M) services using CPT codes 99291 and 99292 when they have operated on the patient who requires critical care services. However, it is commonly the case that the operating surgeon can bill for surgical critical care as well as any other E/M service (such as a daily inpatient visit CPT code: 99231, 99232, or 99233) if certain conditions are met. Following is further guidance on this issue with a historical perspective on how the rules were developed.

Defining the postoperative period for billing purposes

There are three types of global surgical packages with a different number of postoperative days included in each.

0-Day postoperative period (minor procedures such as endoscopies, arterial and central line insertion, etc.)

10-Day postoperative period (other minor procedures, excision of skin lesions, I&D of abscess, intermediate and complex repairs, etc.). There is no preoperative period and includes services provided on the surgical day and 10 days following the day of surgery.

90-Day postoperative period (major procedures, for example, splenectomy, bowel resection, gastrotomy, etc.). A 1-day preoperative period is included, along with the day of surgery and then 90 days following the surgery.

A complete listing of postoperative periods for surgical procedures can be found in the Medicare Physician Fee Schedule (<https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>).

Global Surgical Package (SGP): included services

The following services are included in the SGP payment and cannot be billed for separately:

- ▶ Follow-up visits during the postoperative period of the surgery that are related to routine recovery from the surgery.
- ▶ Postoperative pain.
- ▶ Supplies, except for those identified by the surgeon (eg, surgical implants).
- ▶ Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes. VAC changes would be included if the patient is in the 10-day or 90-day global period.

Follow-up in office care, including treatment of complications not requiring a return to the operating room, is included in postoperative surgical package. Also, typical in-hospital follow-up care is included in the postoperative surgical package. If critical care services are being rendered, it is logical to appropriately and legitimately bill for them, as payments will be higher.



▶ <http://dx.doi.org/10.1136/tsaco-2020-000578>

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Global Surgical Package: excluded services

These are services that are not included and may be billed for separately. Note that modifiers must be applied in some instances in order to obtain reimbursement. This extensive list of excluded services along with more information on the SGP can be found here:

- ▶ <https://www.aapc.com/blog/46373-your-quick-guide-to-the-global-surgical-package/>

Coders are not clinicians and rely on physician documentation as to why a patient is seen during postoperative period. Documentation should be clear to the coder that the patient is being seen for another condition(s) not related to the surgery. In fact, it is extremely useful to make the focus of a daily progress note be that of the other unrelated conditions and only mention the operation in passing; that will help emphasize the point that the care being provided during this particular encounter is for a condition that is unrelated to the operation.

More information on global periods is available in the Medicare Global Surgery Booklet found online (www.cms.gov).

A restricted understanding of what is meant by “unrelated to the surgery” is essential. The focus is specifically related to the surgical procedure performed on a specific part of the body.

Adding modifier 59 on the charge for any additional procedure (eg, central line) will permit that additional procedure to be reimbursed.

Commonly, those conditions that make a patient critically ill are usually not a routine consequence of a surgical procedure. For example, a patient may develop severe respiratory failure needing mechanical ventilation postoperatively from a bowel resection; respiratory failure is not a “usual, customary, or reasonable” consequence of that procedure. Therefore, it follows that it is not part of the surgical global package postoperatively and billing for care to treat them is allowable using the appropriate modifiers where applicable.

Conclusion

It should be a rare occasion that a surgeon cannot bill for critical care services and procedures on a patient on whom they have operated on. Such billing does, however, require the appropriate documentation and coding to enable payment for those services during the surgical global package period. Knowledge of, and appropriate application of, modifiers is important in order to clearly represent the relationship between the initial operation, subsequent operations and critical care services and procedures performed perioperatively.

The following resources provide additional information on this topic.

- ▶ <https://www.cms.gov/> (accessed May 18, 2020)
- ▶ <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx> (accessed May 18, 2020)
- ▶ Mabry CD. In their own words. The Five-Year Review, E&M services, and ACS leadership. *Bull Am Coll Surg* 1998;83:41–5.
- ▶ Reed RL 2nd, Luchette FA, Esposito TJ, *et al.* Medicare’s “Global” terrorism: where is the pay for performance? *J Trauma* 2008;64:374–83; discussion 383–4.
- ▶ *Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Section 40.1: Definition of a Global Surgical Package.* 90–94.
- ▶ <https://www.aapc.com/blog/46373-your-quick-guide-to-the-global-surgical-package/> (accessed June 1, 2020)
- ▶ *Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Section 30.6.12 – Critical Care*

Visits and Neonatal Intensive Care (Codes 99291–99292), Subsection J: Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician as Critical Care Codes 99291–99292. 74.

- ▶ <https://campus.ahima.org/audio/2007/RB020807.pdf> (accessed June 9, 2020)

DOCUMENTATION AND CODING IN CONJUNCTION WITH TRAINEES AND ADVANCED PRACTITIONERS

Introduction

This section deals with the complexities of billing for, and with, the various levels of adjunctive staff who help deliver services to patients. In order to assure proper compensation at the appropriate level for all who are entitled to it, knowledge of the rules and details of documentation necessary by all providers is essential. It is also important in avoiding claims of fraudulent billing by taking credit for services that should not be credited to, and therefore not billable by, the surgeon.

Documentation in conjunction with medical students

In 2019, the Centers for Medicare and Medicaid Services (CMS) changed its requirements for teaching physicians to bill for services that involve *medical students* (not residents, who have earned their MDs). The intent was to make it easier for the teaching or attending physician to sign off on a student’s note without having to re-document key components of an evaluation and management (E/M) service.

While Medicare does not pay for services furnished by medical students, it does pay for teaching physicians’ services that involved a medical student being trained who contributed to the documentation.

Previously, the physician had to re-document elements of the history and examination that were captured by the student, now the physician simply needs to refer back to that documentation and state that he or she has reviewed and verified it.

Documentation in conjunction with residents

In order for the teaching physician to bill for an E/M service performed in part or wholly by a resident MD/DO, the documentation must include the following elements:

An attestation statement from the teaching physician

This states that the physician either performed the entire service with the resident observing, or that the physician was physically present with the resident while he or she performed the key components of the E/M service. The attestation must also be clear that while the resident can perform the key components, the physician participated in managing the patient and has signed off on the assessment and plan component of the service.

A timely signature from both the resident and teaching physician

CMS has not specified a precise number of days or hours beyond which it no longer considers a signature “timely,” but it is generally recommend that signatures occur no more than 48 hours after the date of service.

Append modifier GC if required

Medicare and many commercial payers require that modifier GC (this designates that the service has been performed in part by a resident under the direction of a teaching physician) be appended to the E/M code for any visit involving some care provided by a resident. Modifier GC does not impact payment, but it is used

to certify that the billing physician has complied with the afore requirements.

Simple attestation statements such as “rounded, reviewed, and agree” or “discussed case with resident, agree with plan,” while appearing commonly, fail the basic requirement from CMS that the attestation explicitly supports the physical presence of the teaching physician during the encounter.

Teaching physician guidelines for surgical procedures

Minor surgical procedures

Procedures that take only a few minutes to complete (eg, simple suture): In order to bill, the teaching physician must be present for the entire procedure. The teaching physician or resident may document the teaching physician’s presence for the entire procedure

High risk and complex surgical procedures

In order to bill, the teaching physician must be present during all critical or key portions of the procedure and be immediately available to furnish services during the entire procedure or arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed. The teaching physician determines what constitutes the critical or key portions of the procedure. If the teaching physician is present for the entire procedure, either the teaching physician or the resident may document the teaching physician’s presence for the entire procedure. If the teaching physician is present only for the critical or key portions of the procedure, a statement to that effect documenting the teaching physician’s presence at that time and immediate availability or the immediate availability of another qualified surgeon must be placed in the medical record. These statements can be incorporated in the Procedure/Op note which can be templated.

Endoscopic procedures

In order to bill, the teaching physician must be present during the entire viewing. The entire viewing begins at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing the entire procedure through a monitor in another room does not qualify. Either teaching physician or resident may document the teaching physician’s presence for the entire procedure.

Two overlapping surgeries

This is sometimes referred to as “running two rooms.” In order to bill, the teaching physician must be present during the critical or key portions of both procedures. The critical or key portions of each surgery may not take place at the same time. When a teaching physician is not present during non-critical or non-key portions of a surgical procedure and is participating in the critical or key portions of another surgical procedure, that surgeon must arrange for another qualified surgeon to be immediately available to assist the unattended resident should the need arise. The teaching physician must document their presence during the critical or key portions of each surgery and specify the other qualified surgeon who was immediately available

Some examples of acceptable statements documenting presence of the teaching physician follow.

Resident statements

- ▶ Dr. Smith was present during the entire procedure.
- ▶ This entire procedure was performed under the personal supervision of Dr. Smith.

Teaching physician statements

- ▶ I was personally present throughout the entire procedure.
- ▶ I was personally present during the key portions of this procedure and immediately available throughout the entire procedure.
- ▶ I was personally present during the key portions of this procedure. Dr. XX, a qualified surgeon, was immediately available for the remainder of the procedure.

DOCUMENTATION IN CONJUNCTION WITH ADVANCED PRACTITIONER PROFESSIONALS

Failure to document and bill properly for services rendered by these professionals can result in serious revenue cycle errors and loss of income.

Many providers are still having difficulty with the non-physician practitioner (NPP) billing rules from the Centers for Medicare & Medicaid Services (CMS). Most facilities are now referring to NPPs as Advanced Practitioner Professionals or APPs. These rules are poorly understood and therefore not uniformly followed. Also adding to the confusion is that not all payers follow Medicare’s NPP billing guidelines. Therefore, it is important that coders be familiar with each contracted payer’s policies understanding and following their particular guidelines.

The classification of NPP or APP encompasses

- ▶ Physician assistants (PAs)
- ▶ Nurse practitioners (NPs)
- ▶ Clinical nurse specialists (CNSs)

Medicare does not credential auxiliary personnel, that is, staff that works in the hospital or office who are not licensed to manage care.

APPs may perform services within their scope of practice. They may

- ▶ Perform office visits;
- ▶ Assist in surgery;
- ▶ Perform office procedures; and
- ▶ Perform other services within the state scope of practice (state laws and regulations).

CMS, recognizes three types of NPP/APP billing:

- ▶ Incident-to services
- ▶ Split/shared services
- ▶ Direct billing services

Incident-to services

These services are rendered by the APP but billed under a physician’s NPI number, with payment at 100% of the Medicare allowable. If the APP bills directly to Medicare under their own NPI number, then payment is reduced to 85% of the Medicare fee schedule allowable. Incident-to services are not allowed in the hospital setting, including the emergency department. CMS considers NPPs “Auxiliary personnel” which means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

To meet the billing requirements, a course of treatment and plan of care must be initiated by a physician and reflect continuing active participation and management of care. The physician must see the patient periodically to remain an active participant. An APP may not bill incident-to service for evaluation or management of a new patient or established patient with a new or worsening problem. Even though it is not required, it is recommended that the physician supervising co-sign the

APP's documentation to validate the incident-to service. A certain percentage of the APP's documentation must be reviewed periodically.

Supervision does not have to be provided by the physician who routinely oversees the APP, but any physician in the group who is in the office suite on the date of service. There must be a physician in the same office suite as the APP who is immediately available to provide assistance or direction to the NPP.

The APP must be employed, leased, or serving as an independent contractor of the physician or group, or a legal entity that employs or contracts the physician. All services provided incident-to must be within the APP's state scope of practice.

Some non-Medicare payers may require Modifier SA when billing for incident-to services under the physician's NPI number. Please check with each individual payer.

Split/shared services

These services are rendered by both the NPP and the physician and are typically billed by the physician (but may be billed by the NPP). It is more advantageous to bill under the physician, who is paid at 100% of the fee schedule allowable rather than accept a 15% reduction in reimbursement to the NPP.

The NPP and a physician share a visit, each performing and documenting a portion of the history, examination, and medical decision-making. The documentation may then be combined to arrive at a level of service. Usually one practitioner sees the patient and documents a note, and either the physician or NPP follow-up later on the same date, seeing the patient and documenting a visit note. Both visits can be combined and billed under the physician's NPI number, which is preferable.

Split/shared billing applies to both office and hospital settings. Providers cannot split/share critical care services, bedside services, or surgical procedures. A consult cannot be split/shared when billed under incident-to service. It must be a direct bill.

An NPP can only bill under their own NPI number under direct billing. In the office setting, to split/share a visit, incident-to service guidelines must still be met. For example, an established patient with an existing plan of care and no new problems, with all other incident-to service criteria met, may be billed under the physician's name and number. There is no benefit to split/share a visit in the office because incident-to service guidelines must still apply for the NPP. It is actually over-utilizing resources by split/sharing.

The split/shared rule applies only to physicians and APPs who are employed by the same entity. A shared service between a hospital-employed APP and a private physician may not be billed as a shared visit. The physician may report the service that they performed and documented, but may not use the hospital employed APP's documentation to determine the level of service.

Direct billing

Under direct billing, the APP provides the entire service in any setting, including the office and hospital. The service is reported under the APP's NPI number. It is wise to confirm the payer recognizes the service of the APP, and that the APP is properly credentialed if the payer requires it.

Under direct billing:

- ▶ The NPP provides the entire service.
- ▶ Can be a new patient, an established patient, or an established patient with a new problem. Can also be reported for critical care services.
- ▶ No plan of care needs to be in place. No prior visit is required.

- ▶ The physician does not need to be in the office suite if it is an office visit.
- ▶ The service can be delivered in the office or hospital settings, including the ED and critical care.
- ▶ For critical care services, this includes E/M services, bedside procedures, and any other services not bundled under critical care.
- ▶ The service is billed under the NPP's name and NPI number and is reimbursed at 85% of the physician fee.
- ▶ All procedures performed by an NPP in the hospital setting must be billed direct, under the NPP's name and number.

NPPs can assist in surgical procedures if this is within their scope of practice. In this case, Modifier AS should be applied. The operative report must state how the APP assisted in surgery. Many payers, including Medicare, expect this during an audit as this is the basis for additional expenditures they must make for the assistant's services.

For assistance at surgery by an NPP:

- ▶ Always direct bill using the NPP's NPI to Medicare, and append Modifier AS to all CPT codes.
- ▶ Assistant-at-surgery services are reimbursed at about 14% of the MPFS allowable (85% of the 16% MPFS allowable for an assistant surgeon).
- ▶ A separate operative report is not required.
- ▶ Documentation must include the PA's or NP's involvement as an assistant, not just their name in the heading of the operative report.

Conclusion

Understanding how to bill for the APP is critical to a surgeon's practice, whether they see patients in the office or hospital setting. Surgeons and groups hiring APPs should be aware of the different required billing for NPPs, what services payers allow NPPs to provide, what payers follow Medicare rules, and if they do not, what rules they do follow. Not understanding how to bill the NPP service can result in a serious impact on revenue capture and lost income.

CODING SELECT PROCEDURES

Conscious Sedation

Conscious Sedation: definition

Conscious sedation is often employed by the Acute Care Surgeon to facilitate performance of minor diagnostic or therapeutic procedures such as endoscopy, reductions of fractures or dislocations, tube thoracostomy, and so on without the involvement of an anesthesiologist or nurse anesthetist. Most commonly, it is utilized in awake patients who are not intubated but can also be applied to those who are intubated if they are not considered under deep sedation. This service should be billed for separately and is not generally included as part of the primary procedure being performed (ie, not bundled). Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation, deep sedation, or monitored anesthesia care.

Qualifying providers

Any physician can bill for conscious sedation, although most facilities require appropriate credentialing of the physician for the sedation procedures employed. Some facilities may similarly allow nurse practitioners and/or physician assistants to provide the sedation services. Billing for professional services is governed by the provider having a Medicare Specialty Code (NPI).

Relevant CPT codes

- ▶ **99151:** Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service, initial 15 min, patient younger than 5 years of age (wRVUs—0.50).
- ▶ **99152:** Initial 15 min of intra-service time, patient age 5 years or older (wRVUs—0.25).
- ▶ **99153:** Each additional 15 min, list with primary service code (wRVUs—0.00). (Note: Medicare does not pay for this code. The physician's work is paid under primary codes 99151 and 99152.)
- ▶ **99155:** Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service, initial 15 min, patient younger than 5 years of age (wRVUs—1.90)
- ▶ **99156:** Initial 15 min of intra-service time, patient age 5 years or older (wRVUs—1.65).
- ▶ **99157:** Each additional 15 min, list with primary service code (wRVUs—1.25).

The difference between codes 99151–99153 and 99155–99157 is whether one or two providers are involved in providing procedural services. That is, codes 99151–99153 involve only one provider performing both the sedation and procedural services while 99155–99157 involve two providers performing each of the services separately.

Conscious sedation usually requires monitoring by an independent trained observer. That person is an individual who is qualified to monitor the patient during the procedure and who has no other duties (such as assisting in the operation) during the procedure.

Included Evaluation & Management (E/M) Services

Like most procedural CPT codes, conscious sedation also includes E/M services. All the conscious sedation codes are “0-day” global package period procedures. What that means is that if the individual who performed the conscious sedation procedure (or the individual's partner from the same specialty) performs another E/M service (such as daily rounds) on the same day for conditions unrelated to the conscious sedation procedure, a modifier (likely the “25” modifier) will need to be applied to the CPT code for that E/M service. Without the modifier applied to the other E/M service, payment for that E/M service will be denied.

Despite the assumption that E&M services are included in payment for conscious sedation, no documentation of those E/M services are required for payment of the service. As an example, another common 0-day procedure is that of a central venous catheter insertion. The documentation for central venous catheter insertion does not require any E/M components to justify its payment; simply the essential aspects of the procedure itself need to be documented.

Like all procedures, conscious sedation involves pre-service work, intra-service work, and post-service work. The reasons for these defined components is that payments are based on 15 min segments of “intra-service work” only. No credit is allowed for any additional time spent in pre-service or post-service work. Details of the services involved in the three phases of work can be found online (<https://inospirehealth.com/moderate-sedation-cpt-code/>).

Intra-service time begins with the administration of sedating agents and time ends when the physician or qualified healthcare professional finishes the procedure, the patient is ready to go to recovery and the provider who performs moderate sedation ends

“personal continuous face to face time with the patient” (when the physician leaves the room).

Examples of notes containing appropriate documentation to support conscious sedation billing follow. These can be templated and stored in the EMR.

- a. After pre-procedural evaluation, intravenous moderate sedation using ___ with continuous physiologic monitoring provided by a qualified registered nurse under the direct supervision of the attending physician for __ minutes.
- b. I was personally responsible for the pre-procedural evaluation, administration of moderate conscious sedation, and post-procedural management, including the use of an independent trained observer. The drug(s) given were _____. Total face-to-face time was ___ minutes. (Note: An independent trained observer is an individual who is qualified to monitor the patient during the procedure, who has no other duties during the procedure.)
- c. Prior to the procedure, the patient's airway and overall health was assessed, and IV access was obtained. Throughout the length of the procedure which required ___ minutes, I coordinated the administration of _____ as documented in the nursing records in order to maintain the conscious sedation of the patient throughout in addition to continuous physiologic monitoring of oxygen saturation, heart rate, and blood pressure and recovery.
- d. Moderate conscious sedation was provided using _____. Monitoring was provided by a qualified registered nurse under my direct supervision for ___ minutes.

The following resources provide additional information on this topic:

- ▶ <https://www.medicalbillersandcoders.com/blog/moderate-conscious-sedation-coding-guidelines/> (accessed June 9, 2020)
- ▶ <https://www.aapc.com/blog/46593-moderate-sedation-coding/> (accessed June 9, 2020)

Tracheostomy

Code 31600 *Tracheostomy, planned (separate procedure)* describes a planned tracheostomy; however, if the patient is under 2 years of age, 31601 should be used. Code 31600 is reported for “percutaneous” tracheostomy as well. This procedure can be performed with or without a bronchoscope. The bronchoscope, used as a light source and to remove blood and secretions, is NOT separately reported.

When a tracheostomy is performed in an emergency, 31603 *Tracheostomy, emergency procedure; transtracheal* for a transtracheal approach should be reported or 31605 *Tracheostomy, emergency procedure; cricothyroid membrane* if the incision is made in the neck over the cricothyroid membrane. Documentation should clearly distinguish between an emergency procedure and a planned one. The technique, percutaneous versus conventional or open, also needs documentation along with whether the procedure was transtracheal or through the cricothyroid membrane. Inclusion of text noting performance of the procedure in a daily progress note or ED E/M note does not suffice. A separate procedure note must be written. Avoid using the abbreviated terms “Trach” and “Cric” but rather use the full words.

Most tracheostomy codes have a 0-day global period.

Tracheostomy changes

CPT contains just a single code for tracheostomy tube change: 31502. However, 31502 may not be the appropriate code for

this service in some instances since it describes tube changes before formation of a fistulous tract.

For in-office tube changes, a separate service cannot be claimed, but the cost of supplies possibly can be. Tube changes in the OR can be claimed. The time interval between original placement and the change determines if code 31502 should be applied. The code 31502 should be used only when the provider changes a tracheostomy tube before the fistula tract has become established. CPT does not provide specific guidelines on when the fistula tract becomes established. This determination is left to the physician's clinical judgment. However, the tract is usually considered to be established within 7 to 10 postoperative days of the tracheostomy. Changing the tube when the tract is immature is considerably more difficult than changing a tube after the tract has healed but does not routinely generate a 22 modifier. The status of tract maturity must be clearly stated in a procedure note to support billing.

In the case of an established tract, an E/M service for trach tube changes in the office, nursing home or bedside after the fistula tract has healed cannot be reported as a separate procedure code. However, the trach change should be considered as a factor when deciding on an appropriate-level E/M service for the encounter.

Additional information on this topic are available in the following resources:

- ▶ [https://journal.chestnet.org/article/S0012-3692\(18\)32862-9/fulltext](https://journal.chestnet.org/article/S0012-3692(18)32862-9/fulltext) (accessed June 9, 2020)
- ▶ <https://www.supercoder.com/coding-newsletters/my-general-surgery-coding-alert/trach-tips-coding-strategies-to-optimize-reimbursement-article> (accessed June 9, 2020)

Gastrostomy

The codes for percutaneous endoscopic gastrostomy (PEG) tubes or J-tubes follow. Also, if performed in conjunction with a concomitant tracheostomy, a 59 modifier should be applied.

Diagnostic upper endoscopy

- ▶ **Code 43235:** Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed.

Placement procedures

- ▶ **Code 43246:** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube (PEG).
- ▶ **Code 43830:** Open (Stamm) gastrostomy. Open placement is a separate procedure. Therefore, 43830 cannot be reported separately if open placement takes place the same day as another procedure in the upper abdominal or stomach area. It can, however, be billed with a procedure in the lower abdomen (eg, sigmoid colectomy). To distinguish a separate procedure, use 59.
- ▶ **Code 43832:** Describes a Janeway gastrostomy which is much less frequently performed.
- ▶ **Code 44300:** Placement of an enterostomy or cecostomy tube using open technique (eg, for feeding or decompression). This is a separate procedure and can be billed separately when done in conjunction with other abdominal surgery using the 59 modifier.
- ▶ **Code 44373:** Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to

percutaneous jejunostomy tube. This is in the repertoire of some Acute Care Surgeons.

Replacement procedures

- ▶ **Code 43672:** Replacement of gastrostomy tube, percutaneous, includes removal when performed, without imaging or endoscopic guidance; not requiring revision of a gastrostomy tract.
- ▶ **Code 43673:** Replacement of gastrostomy tube, percutaneous, includes removal when performed, without imaging or endoscopic guidance; requiring revision of a gastrostomy tract.
- ▶ **Code 49450:** Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
- ▶ **Code: 49450:** Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report.
- ▶ **Code 43246:** Esophagogastroduodenoscopy, flexible, transoral; with directed replacement of percutaneous gastrostomy tube. Do not report removal of the tube prior to replacement.

Mechanical removal of tube obstructions

- ▶ **Code 49460:** Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastrojejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed.

Tube removal

- ▶ **Code 43870:** Closure of gastrostomy, surgical. *Note:* There MUST be stitches placed with a surgical closure to use this code. It is important to understand that if no stitches are placed and the tube is just pulled and steri-strips are put over the gastrostomy opening, coders must report code 49999, the unlisted GI code, since there is no code for this process. Remember also that Medicare does not accept unlisted codes.

Feeding tube placement documentation

The documentation should communicate critical information about the patient's diagnosis, treatment, progress, and discharge status to other providers and also provide the information needed to justify services in the event of an audit by the payer. If information in the documentation is insufficient or does not support the billing codes, claims may be denied.

Please see the following resource for more information on this topic:

- ▶ <https://info.prsnetwork.com/peg-tube-placement-cpt-code/>

Bronchoscopy

Most often, the Acute Care Surgeon uses a fiberoptic scope rather than a rigid scope and usually performs the procedure at the ICU bedside with the patient intubated. Other locations include an office setting or perhaps in an endoscopy suite.

Several types of diagnostic and therapeutic procedures are often done through the bronchoscope, most commonly bronchoalveolar lavage (BAL) for toilet, such as clearing mucous plugs, or diagnosis such as obtaining specimens for culture and sensitivity. Indications involving the investigation of abnormalities and evaluating other conditions such as pulmonary hemorrhage or removal of foreign

bodies are also not uncommon. Biopsies, brushings or BALs are included in the 31623–31633 range of codes. During bronchoscopies, physicians may also acquire specimens of an abnormality (eg, infection, tumor) that are then analyzed by a pathologist. Therapeutic procedures include use of the scope to remove foreign bodies such as inhaled pieces of food. These procedures are included in the 31630–31646 code range.

Because both sets of guidelines (CPT and Medicare) bundle 31622 into all other bronchoscopy services, only the “surgical” procedure, the BAL, should be reported using 31624. This code reflects a more complicated process and sampling than the diagnostic bronchoscopy with bronchial washing code, 31622, does. Guidelines at the beginning of this CPT section qualify that a diagnostic bronchoscopy is always included with any of the other surgical bronchoscopy codes when completed by the same physician. One should be aware of this exclusionary edit and not attempt to bill for 31622 in conjunction with other bronchoscopy codes.

A diagnostic bronchoscopy is inherently bilateral. The code should be reported only once because inspecting both of the mainstem bronchi is innately part of the procedure. Having said that, some clarification is in order. From a coding perspective, the series of codes 31623 through 31656 describe unilateral procedures. To indicate that a procedure from this series was performed bilaterally, modifier –50, Bilateral procedure, should be appended to the appropriate code. Therefore, modifier –50 should be appended to code 31624 when bronchial alveolar lavage is performed bilaterally. Again please note the distinction that code 31622, Bronchoscopy (rigid or flexible), diagnostic; with or without cell washing (separate procedure), is inherently bilateral, so it would not be appropriate to append modifier –50 to code 31622. Appropriate documentation of either procedure is key to appropriate compensation.

As always, payers may have differing payment policies on the bronchoscopy code set. Questions regarding the billing of multiple codes within the section are frequent. Physicians and coding professionals must be attentive to the documentation, CPT instructions and the individual payer to achieve efficient and timely reimbursement.

Additional information on this topic can be found in the following resource:

- ▶ [https://journal.chestnet.org/article/S0012-3692\(19\)30158-8/fulltext](https://journal.chestnet.org/article/S0012-3692(19)30158-8/fulltext) (accessed June 9, 2020)

Colonoscopy

If a surgeon performs a diagnostic colonoscopy for a Medicare beneficiary, the appropriate CPT code that describes procedure, such as 45378 (Colonoscopy, flexible; diagnostic, including

collection of specimen[s] by brushing or washing, when performed [separate procedure]), should be reported.

Screening colonoscopies for Medicare beneficiaries should be reported using one of the following codes:

- ▶ **G0105** (Colorectal cancer screening; colonoscopy on individual at high risk).
- ▶ **G0121** (Colorectal cancer screening; colonoscopy on individual not meeting the criteria for high risk).
 - For non-Medicare payers, report a screening or diagnostic colonoscopy that involves no further intervention using 45378.
 - Whether for Medicare or non-Medicare payers, if a lesion or condition is found during the colonoscopy that results in further intervention, use the appropriate CPT code, such as one of the following:
- ▶ **45380** (Colonoscopy, flexible; with biopsy, single or multiple).
- ▶ **45384** (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps).
- ▶ Append the CPT modifier 33 (Preventive service) for non-Medicare payers, and the HCPCS Level II modifier PT (Colorectal cancer screening test, converted to diagnostic test or other procedure) for Medicare to properly represent and be reimbursed for this situation.

The following resources provide additional information on colonoscopy:

- ▶ <https://codingintel.com/coding-for-screening-colonoscopy/> (accessed June 9, 2020)
- ▶ <https://www.outsourcestrategies.com/blog/brush-up-on-colonoscopy-billing-codes-and-guidelines.html> (accessed June 9, 2020)

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