asim
american society of internal medicine

March 5, 1996

Correct Coding Initiative
AdminaStar Federal, Inc.
P.O. Box 50469
Indianapolis, IN 46250-0469

The American Society of Internal Medicine (ASIM) is disappointed that the *National Correct Coding Policy Manual For Part B Medicare Carriers, Version 2* does not take into account many of the concerns ASIM raised in our February 23, 1995 letter (enclosed) regarding the draft policy manual.

Attached are ASIM's comments on Version 2 of the *National Correction Coding Policy Manual For Part B Medicare Carriers.* ASIM was led to believe that all the coding pairs questioned by medical specialty societies last year would either be removed from the manual or would be addressed prior to the January 1, 1996 implementation of the manual. This does not appear to be the case.

Jean Harris, from the Health Care Financing Administration (HCFA), indicated that AdminaStar Federal will respond to our specific concerns within two to three weeks of receiving these comments. We request that your response describe why each specific coding pair cited in our comments was included in the manual.

Sincerely,

Glenn Littenberg, MD

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CPT/RBRVS Committee Chair

cc James M. Gaither, MD
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American Society of Internal Medicine (ASIM)

Comments on

The *Correct Coding Policy Manual for Part B Medicare Carriers (Version 2)*

Mutually Exclusive Coding Pairs

The coding pairs listed below are services that ASIM objected to in our comments on the draft correct coding policy, dated February 23, 1995, but are included in the "mutually exclusive" list. We request that AdminaStar Federal's response describe why each specific coding pair cited below was included in the *National Correct Coding Policy Manual For Part B Medicare Carriers, Version 2.*

43450/43453 (IB-48) If performed at the same session, payment for these services should be governed by multiple code (-51) rules. There are times when an unguided bougie is not successful at reaching the desired diameter and consequently a guide wire must be passed and dilation accomplished by a second form of dilators. These are not mutually exclusive procedures.

43265/43264 (IB-48) Removal of stones may be provided during the same session as lithotripsy of stones, as multiple techniques may be needed at the same session to rid the duct of stones. The work involved can be substantial and in fact if both techniques were needed, it is likely that substantial work was required. Payment rules should reflect the following: if one or more stones cannot be removed with techniques other than lithotripsy, then only the lithotripsy code should be billed. However, if one or more stones are removed by nonlithotripsy techniques and subsequently other stones are removed by lithotripsy technique, it is legitimate to bill with both codes. It is reasonable to require -GB modifier on the lesser procedure to identify this situation. It is reasonable to reimburse for the procedures using the family of endoscopy codes rules.

45355/45383 (IB-49) Current Procedural Terminology (CPT) currently has only one code to identify a colonoscopy performed within the operating room through colotomy (transabdominal approach) except code 45355, which does not recognize situations when lesions are treated through the scope--polypectomy, removal of foreign body. Use of 45355 should be allowable along with any of the 453XX codes or 4533X codes, including with the basic diagnostic codes 45330 or 45378, reflecting performance of specific services at the time of colotomy for performing the scope. There is unique time and work requirements to perform any scope procedure via colotomy, recognized at approximately half of any of the full colonoscopy code relative value units. If billed in conjunction with other codes, the 45355 code should be recognized by -51 multiple procedure rules.

47500/43264 (IB-49) Though these services would seldom be billed together, they are substantially different services, not mutually exclusive. It is possible that stones might be removed by ERCP, but that percutaneous transhepatic cholangiography might also be needed to define a lesion not adequately defined by the dye injection at ERCP. Multiple procedure payment rules for modifier -51 should govern this situation.

Comprehensive Coding Pairs

The coding pairs listed below are services that ASIM objected to in our comments on the draft correct coding policy, dated February 23, 1995, but are included in the "comprehensive" list. We request that AdminaStar Federal's response describe why each specific coding pair cited below was included in the *National Correct Coding Policy Manual For Part B Medicare Carriers, Version 2.*

44386/44361 (VIB-43) Small intestine pouch evaluation with biopsy and small intestine endoscopy codes (4436X) would seldom be billed together since they are usually done for different purposes. However, if performed the same day by the same examiner, it is appropriate that multiple procedure -51 rules pertain to their recognition and payment. The small intestine endoscopy code involves oral intubation and passage of a scope beyond the duodenum; where pouch evaluation is a retrograde procedure for visualization of a surgically created pouch at the end of the small intestine.

44386/44377 (VIB-43) Small intestine pouch evaluation with biopsy and small intestine endoscopy codes (4436X) would seldom be billed together since they are usually done for different purposes. However, if performed the same day by the same examiner, it is appropriate that multiple procedure -51 rules pertain to their recognition and payment. The small intestine endoscopy code involves oral intubation and passage of a scope beyond the duodenum; where pouch evaluation is a retrograde procedure for visualization of a surgically created pouch at the end of the small intestine.

91012/91033 (XIB-10) It is inappropriate to consider these services bundled. The CPT definition may not be optimal, but does describe two different distinct procedures. The former studies esophageal motility while acid is being perfused into the esophagus. The latter is a prolonged study of pH in the esophagus with a patient being ambulatory and a study of spontaneous pH changes that occur over time. It is not a motility study primarily, although at times motility is recorded in the same context. Regardless, these are two distinct procedures. If performed the same day by the same examiner, multiple procedure rules -51 would apply.

99354/71010, 99354/71020, 99354/93040, 99354/934041, 99354/93042 (XIB-43) It appears erroneous that these five coding pairs were listed as part of a level four inpatient consultation. Chest X-rays and rhythm EKG are not part of a consultation.

VIA-2-B Gastroenterologic tests 91000-91299 are not complementary to endoscopic procedures and should be recognized separately from upper GI endoscopic procedures. In fact, CPT 91000 esophageal intubation and 91055 gastric intubation would seldom be performed the same day and in the same patient as an upper GI endoscopic procedure, but if they are performed on separate days it would be legitimate to bill. This would reflect the inability of one technique to achieve the diagnostic information hoped for. This is no different than providing a CAT scan on the second day if an ultrasound study provided on the first day wasn't diagnostic. Comment 3 is incorrect in stating that provocative testing 91052 can be expedited during endoscopy and therefore should be billed with a -52 modifier. Provocative testing requirements technically and in terms of time and physician work are no different whether performed the same day as an endoscopy or not; an NG tube placement, IV injection of stimulant and collection of multiple specimens over time of gastric content with subsequent analysis of gastric acid are the definition of provocative testing, and is no way expedited by endoscopy.

43243/43255 (VIB-12) It is acceptable to use both codes with a -GB modifier on the lesser code if there are two separate lesions treated by two modalities at the same session, such as injection/cautery of an ulcer, and injection sclerotherapy of varices. This would occur infrequently, but should be recognized and paid for by family of code rules.

43244/43255 (VIB-13) It is acceptable to use both codes with a -GB modifier on the lesser code if ligation of varices is performed and a separate bleeding lesion is treated at same session by a different technique.

43246/43202 (VIB-13) It is legitimate to biopsy a lesion during esophagoscopy and to place a percutaneous gastrostomy tube during the same session, although usually the code 43239 would be used rather than 43202, since the stomach is entered (by definition). Since we do not biopsy the site of a gastrostomy placement, there should be no need to use a -GB or other modifier. The corresponding payment rule would be guided by family of code rules.

43246/43761 (VIB-13) It is legitimate to report both codes the same day from the same session. There are times when a gastrostomy tube is placed, but it is necessary to directly change the gastrostomy feeding port into a tube placed into the duodenum or jejunum. There is substantial work involved in this service, since it requires endoscopically dragging a tube passed through the finished gastrostomy down into the small intestine and assuring it is left in place. Payment under family of code rules should pertain to this situation.

43247/43202 (VIB-14) It is legitimate to report codes for biopsy (43202, 43239) at same time as a foreign body is removed from the upper GI tract. Usually a separate problem has been discovered while removing the foreign body, which requires biopsy to diagnose. Rarely will this be a biopsy of a lesion such as a stricture that is causing the foreign body (such as a food bolus) to get stuck. These are not bundled codes; and should be recognized within the family of code rules.

43255/43202 and 43255/43204 (VIB-15) If different sites are being biopsied or treated for hemorrhage by different techniques, then both code pairs can be legitimately reported, using -GB modifier for the lesser service.

43264/43215 (VIB-17) Although it would be unusual, it might be necessary to remove an esophageal foreign body and then proceed to remove gallstones by ERCP in the course of a single setting. These are not inherently bundled codes, but the circumstances of needing both services at the same time would be quite rare. If reported together, modifier -51 payment rules would apply.

44377/44366 (VIB-42) Although unusual, it would be legitimate to report biopsy of one lesion and treatment of bleeding from a second site during one procedure. The -GB modifier would be reasonably used to report the involvement of 2 sites with 2 modalities. The family of code rules should be used for payment.

44378/44361, 44378/ 44364, 44378/ 44365, 44378/ 44366, 44378/ 44369, 44378/ 44372, and 44378/ 44373 (VIB-42) Endoscopy with control of bleeding in the course of performing enteroscopy as far as the ileum would include only code 44366, which just refers to a scope with bleeding control that hasn't reached as far as the ileum. Other endoscopic modalities such as removing polyps, taking biopsies (of lesions separate from that treated for bleeding), placing jejunostomy tubes, etc. could all potentially be reported during the same session, although some of these combinations are certainly improbable. In these cases, it isn't unreasonable to ask for use of -GB modifier to reflect that 2 lesions/sites were involved. The family of code rules would apply to payment.

44386/44361 and 44386/44377 (VIB-43) As is discussed above, endoscopy of a pouch is a retrograde procedure of the end of the intestine where a surgically-created pouch is being examined. If an antegrade procedure is carried out (scope passed orally down into small intestine), it would be legitimate to perform biopsies separately, and to submit both codes. Recognition of these services using -51 multiple procedure rules should apply.

44389/44391 (VIB-44) Similar to the discussion above, it might be appropriate to biopsy one lesion and control bleeding from another. Use of -GB modifier would indicate this situation and payment under family of code rules would apply.

45303/45317 (VIB-47) Rigid sigmoidoscopy with dilation of a stricture and control of bleeding would seldom be simultaneously performed, but if reported together would essentially always reflect two lesions needing different treatments. Modifiers shouldn't be required and family of code rules would apply to payment. If bleeding occurred due to dilating a stricture, then the bleeding control code wouldn't normally be reported separately if this was done during the same session.

45307/45317 (VIB-47) Similar to the comments above, both are legitimate services to report, unless bleeding occurred due to removing a foreign body.

45308/45317 (VIB-48) Both services are legitimate to report if different sites are involved, i.e. a polyp is removed from one area and bleeding controlled from another. No special modifier would be needed, in our view. The family of code rules would apply for payment.

45309/45317 (VIB-48) The same comment applies to removal of polyp by snare and control of bleeding, presumably from separate sites.

45320/45317 (VIB-49) The same comment applies.

45321/45317 (VIB-49) The same comment applies, though it would be quite rare that decompression of volvulus and control of bleeding lesion would be performed at same session in same patient.

45331/45334 (VIB-50) As with other pairs, biopsy at one site and control of bleeding at another site are legitimate to report. The -GB modifier would make this situation the most clear, but should not be required. The family of code rules should apply to determine payment.

45332/45334 (VIB-50) Similar to the comments above. Although removing a foreign body and controlling bleeding would seldom be reported together at the same session.

45333/45334 (VIB-50) Similar to the comments above. This coding pair is legitimate to report if two sites are involved.

45337/45334 (VIB-51) Similar to the comments above. It is legitimate though unusual to report decompression of volvulus with control of bleeding at same session.

45338/45334 (VIB-51) Similar to the comments above. It is legitimate to report the removal of a lesion and treatment of bleeding if different sites involved.

45339/45334 (VIB-52) Similar to the comments above.

45379/45382 (VIB-53) Similar to the comments above, removing a foreign body and treating bleeding at different sites or where bleeding isn't a consequence of removing the foreign body is legitimate, though unusual. The family of code rules should apply to payment.

45383/45320 and 45383/45333 (VIB-54) If lesions are treated at different sites and through different lengths/types of scopes, then using the -GB modifier it would be legitimate to report more than one code. Multiple procedure modifier -51 payment rules should apply here.

45384/45382 (VIB-54) Similar to multiple comments above, treatment of bleeding and removal of polyps (by any method) could be reported at the same session if different sites were being treated. The -GB modifier should not be required since the treatment of two sites is typically understood if both codes were to be used.

45385/45333 (VIB-54) This coding pair is no different than reporting 45385 and 45383. Different modalities of treating different polyps, except that 45333, refers to use of the flexible sigmoidoscope. No special modifiers should be needed. Payment should fall under the -51 modifier rather than family of scope rules.

45385/G0001 (VIB-55) These are very different non-bundled procedures. A blood draw isn't inherently a part of colonoscopy of any type.

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