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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Tips Guide Your Lower GI EUS Coding

Consider the new Medicare-allowed codes before you report these services.

Because CPT® 2015 brought significant changes to the lower GI code set, you must be extra careful in choosing your codes when your gastroenterologist performs a lower GI endoscopic ultrasound (EUS). Use these four pointers to successfully navigate the minefield of lower GI EUS.

Background: Lower GI EUS helps the gastroenterologist examine the linings and walls of the lower gastrointestinal tract. The lower tract includes your colon, including cecum and rectum, up to the small intestine. The physician uses a thin, flexible tube called an endoscope with an ultrasound component, which he passes through the anus to the area to be examined and obtains visual images of the lower digestive tract. Lower GI EUS is recommended for staging and/or diagnosis of cancer of the colon and rectum and also for evaluation of anal incontinence.

1. New Definitions Guide Your EUS Codes

Similar to upper esophageal EUS, the lower GI tract has separate ultrasound codes. However, in light of the new definitions of colonoscopy and sigmoidoscopy, go through your physician's op notes carefully, so you'll spot which is the code that will fit best.

Flexible sigmoidoscopy: According to CPT® 2015, you have to report flexible sigmoidoscopy if your physician does not advance the scope beyond the splenic flexure during the endoscopic examination. Flexible sigmoidoscopy should also be reported for endoscopic examination of a patient who has undergone resection of the colon proximal to the sigmoid (e.g., subtotal colectomy) and has an ileo-sigmoid or ileo-rectal anastomosis.

You will report code 45341 (Sigmoidoscopy, flexible; with endoscopic ultrasound examination) for an EUS with sigmoidoscopy.

Colonoscopy: The definition of a complete colonoscopy has been revised. Colonoscopy is now defined as the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. If the physician performs a colonoscopy with EUS, you should report code 45391 (Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures). Your gastroenterologist might use these procedures when a patient has had fecal incontinence or scar tissue. Do not report 45391 more than once per session.

"You cannot report 45378 (Colonoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) with EUS because this is the base code for 45391," informs **Michael Weinstein, MD,** Vice President of Capital Digestive Care. And modifiers won't help you. "In other words, you cannot bill these two codes together under any circumstances. You should only report 45391," he adds.

Colonoscopy through stoma: Colonoscopy through stoma is now defined as the examination of the colon, from the colostomy stoma to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis. If your op notes describe such a procedure along with EUS, you should report newly introduced EUS code 44406 (Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures).

You cannot report 44406 with 44388 (Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed [separate procedure]) as the base colonoscopy is included in the EUS.

2. Combine Appropriate EUS and FNA Codes

Each of the EUS codes corresponds to a related fine needle aspiration (FNA) code.

If your physician records a rectal exam with EUS and fine needle aspiration (FNA), you can use the corresponding FNA codes:

- Therefore, for a flexible sigmoidoscopy with EUS/FNA, you should report code 45342 (Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy[s]).
- For a colonoscopy with EUS/FNA, you will opt for code 45392 (Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures).
- For an EUS/FNA with colonoscopy through stoma, you should go for new 2015 code 44407 (Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures), depending on which service your physician used.

Example: A 62-year-old male was recently diagnosed with a rectal adenocarcinoma by colonoscopy after presenting with hematochezia and anemia. The gastroenterologist is called in again for rectal endoscopic ultrasound. At the time of the exam, enlarged perirectal lymph nodes are found, and the physician performs an EUS FNA.

You will report the EUS session with CPT® code 45392. You should support the procedure with ICD-9 code 154.1 (Malignant neoplasm of rectum).Under ICD-10, you will report the direct crosswalk code C20 (Malignant neoplasm of rectum). Do not report the EUS code in addition to the FNA code. Bill 45392 only. "CPT® includes the base diagnostic colonoscopy code 45378 and the colonoscopy with EUS code 45391 in the code for colonoscopy with EUS/FNA (45392)," Weinstein cautions.

3. Beware of Medicare

You have the requisite codes in hand, but if you think you can bill Medicare with them, then you are inviting trouble. CMS will not be accepting some of the new lower GI endoscopy CPT® codes in the 2015 calendar year (CY), because they have not been valued by the Relative-Value Update Committee (RUC). CMS has created G-codes for specific lower GI endoscopy services to allow practitioners to report services provided to Medicare beneficiaries in CY 2015 the same way they did in CY 2014.

For existing procedures that have new CPT® code assignments in CPT® 2015, CMS requires physicians to report the G-code instead of the corresponding 2015 CPT® code. Therefore, you will not be reporting colonoscopy through stoma EUS code 44406 to Medicare for CY 2015. Instead, you can report either 44388 or G6021 (Unlisted procedure, intestine). Even 44407 can be replaced with the same two codes.

4. Resist Reporting Radiology Codes With EUS

When the physician supervises and interprets the needle placement or the endoscopic ultrasound, CPT® and the Correct Coding Initiative (CCI) restrict the use of three radiology codes with EUS/FNA:

- You cannot bill 76872 (Ultrasound, transrectal) with either 45341, 45342, 45391, or 45392.
- You cannot bill 76942 (Ultrasonic guidance for needle placement [eg, biopsy, aspiration, injection, localization device], imaging supervision and interpretation) with 45341 or 45342.
- You cannot bill 76975 (Gastrointestinal endoscopic ultrasound, supervision and interpretation) with either of 44406, 44407, 45341, 45342, 45391, 45392, or 76942.