2015 General Surgery Survival Guide

Chapter 9: Hemorrhoids

New codes in the block: 45350 & 45398

45350: Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)
45398: Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)

Both the procedures describe insertion of an endoscope to treat the hemorrhoids

Distinguish Between Various Hemorrhoid Procedures

With multiple codes to describe hemorrhoidectomy and yet another for hemorrhoidopexy — a closely related but distinct procedure — you can easily become overwhelmed when trying to report hemorrhoid removal procedures. Fortunately, you can cut through the confusion by following these four tips.

Tip 1: Narrow Selection by Location

Before attempting to choose a hemorrhoidectomy code, you must know whether the hemorrhoids the surgeon removed were internal, external, or a combination of both types.

Internal hemorrhoids are those that originate above the dentate line (a mucocutaneous junction that lies approximately 1 cm to 1.5 cm above the anal verge). Codes that may apply for internal hemorrhoid removal include:

- 46221 (Hemorrhoidectomy, internal, by rubber band ligation[s]). This is by far the most common hemorrhoid removal procedure. During the treatment, the surgeon “ties off” (ligates) the hemorrhoid at its base, which cuts off its blood supply and causes it to shrink over time.
- 46500 (Injection of sclerosing solution, hemorrhoids). During this procedure, the surgeon injects a sclerosing solution into the submucosa of the rectal wall under the hemorrhoid. Once again, this reduces blood flow to the area and causes the hemorrhoid to shrink.
- 46930 (Destruction of internal hemorrhoid[s] by thermal energy [e.g., infrared coagulation, cautery, radiofrequency]). Code 46930 is only for thermal destruction and only for internal hemorrhoids. You cannot use 46930 for the excision of internal hemorrhoids.

The problem: CPT® offers you several hemorrhoid excision codes. However, none of them specify that your surgeon only removed internal hemorrhoids. There are specific codes for external excision and the excision of both internal and external hemorrhoids, but there is not a code for internal alone.

Option 1: You can report an excision of internal hemorrhoids using 46255 (Hemorrhoidectomy, internal and external, simple) with modifier 52 (Reduced services) appended.

Option 2: Alternatively, look at unlisted code 46999 (Unlisted procedure, anus).

Option 3: Codes 46945 (Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group) 46946 (. . . 2 or more hemorrhoid columns/groups), depending on your surgeon's documentation. This procedure is more commonly known as a transfixion suture excision (a crisscross stitch placed so as to control bleeding from a tissue surface or small vessel when it is tied). The physician sutures/ligates the base of the hemorrhoid. Then the remaining hemorrhoid is excised and removed.
**Note:** This is unlike the procedure that you report using 46221. You'll use 46221 when your surgeon ligated or banded the hemorrhoid at base of hemorrhoid by rubber ring banding, expecting the hemorrhoid to shrink over time.

The two most common ways of treating internal hemorrhoids are by ligation/banding, which you'll use 46221 for, and 46945, which you'll use when the surgeon sutured/ligated the hemorrhoid at the base and removed excess tissue.

**Key:** You will need to check with your individual payers to determine which coding option they prefer you use when your general surgeon excises only internal hemorrhoids.

External hemorrhoids originate below the dentate line and can call for a greater variety of treatment options (see "Tip 2" below).

**Watch for:** Your surgeon's documentation should explicitly state the location of the hemorrhoids he treats. If the physician does not directly state "internal" or "external" hemorrhoid, you can read further into the documentation to see if there is a reference to the dentate line.

If the documentation is not clear, be sure to ask the surgeon for details. You can't select a proper code without this knowledge.

**Tip:** Use of a local anesthetic might be a tip-off that the surgeon treated an external hemorrhoid because your physician usually can treat internal hemorrhoids without causing the patient pain.

**Tip 2: Look for Evidence of Thrombosis**

If the surgeon treats external hemorrhoids, you must consider whether the hemorrhoids are thrombosed (clotted).

**Tip:** If a patient presents with symptoms of pain, you are generally dealing with a thrombosed hemorrhoid.

When treating a thrombosed external hemorrhoid, the surgeon has three options:

1. Wait until the hemorrhoid develops into a skin tag and then, if appropriate, remove it. In this case, if the surgeon does remove the skin tag, you should report either 46220 (Excision of single external papilla or tag, anus) or 46230 (Excision of multiple external papillae or tags, anus), depending on whether the surgeon removes a single or multiple tag(s).
2. Perform an incision and drainage (I&D) to remove the clot only. In this circumstance, you would report 46083 (Incision of thrombosed hemorrhoid, external).
3. Perform an excision to obliterate the clot and hemorrhoid at the same time. The best code to describe this procedure is 46320 (Excision of thrombosed hemorrhoid, external).

**Non-thrombosed options:** If the surgeon removes non-thrombosed, external hemorrhoids via excision, you should select 46250 (Hemorrhoidectomy, external, 2 or more columns/groups).

**Tip 3: Turn to Dedicated Codes for 'Mixed' Removals**

The surgeon may also excise a "mixed" or confluent hemorrhoid(s) that begins above the dentate line and extends below it (thus demonstrating attributes of both an external and internal hemorrhoid). In these cases, you should not select one of each code from the external and internal excision codes.

**Instead:** You should use 46255 (Hemorrhoidectomy, internal and external, single column/group) or 46260 (Hemorrhoidectomy, internal and external, 2 or more columns/groups).
Per CPT® guideline, anal column is considered an internal hemorrhoid with 3 major areas in the anal canal: right posterior (1 o'clock), right anterior (5 o'clock), and left lateral (9 o'clock) positions of the anus. The physician must make a subjective judgment based on the number of columns/groups to select the appropriate code.

**Examples:** If the surgeon treats two large hemorrhoids at the right posterior and right anterior positions, the excision would justify the selection of the single column/group code 46255.

**Consider this:** If the surgeon treats an internal hemorrhoid at left lateral and an external hemorrhoid at right posterior, then you would report 46260, because the hemorrhoids are in different columns.

Separate, distinct internal and external hemorrhoids are not the same as a single confluent hemorrhoid that combines external and internal attributes.

**Tip 4: Pay Attention to the Number of Columns/Groups**

In most cases, you may need to report a single code to describe hemorrhoid removal - even if the surgeon removes multiple hemorrhoids during the session, because the code descriptors emphasize on columns/groups rather than numbers.

**Example:** The descriptor for 46500 specifies "hemorrhoids" (plural) which implies you have to report this code only once per session irrespective of the number of hemorrhoids the surgeon treats. Similarly, 46250 now describes removing of multiple hemorrhoids from two or more columns/groups while 46255 covers hemorrhoidectomy for a single column/group. This implies you have to take into account the number of columns/groups of hemorrhoids excised rather than the number of hemorrhoids excised.

**Exception:** Unlike other methods, the excision and I&D of a thrombosed hemorrhoid (46083, 46320) describes only one removal. If the surgeon removes one or more additional thrombosed hemorrhoids, you should bill them separately using 46083 or 46320, as appropriate.

**Bonus Tip: Distinguish Hemorrhoidopexy From Hemorrhoidectomy**

You should be careful not to confuse hemorrhoidopexy — an alternative method for treating prolapsing internal hemorrhoids — with hemorrhoidectomy as described by the methods discussed above.

During hemorrhoidopexy, also called PPH (procedure for prolapse and hemorrhoids), the surgeon performs a progressive anal dilation, inserts a circular anoscope into the anus, and then uses a stapling technique to repair the prolapse.

The appropriate code to report this technique is 46947 (Hemorrhoidopexy [e.g., for prolapsing internal hemorrhoids] by stapling).

**What to look for:** Hemorrhoidopexy does not require that the surgeon remove the hemorrhoidal tissue, as in a typical hemorrhoidectomy. Therefore, coders should read operative notes carefully to be sure the surgeon specifies "stapling" rather than "excision" of the hemorrhoid(s).

**Be sure you meet the requirements:** The most important factor when reporting 46947 is to prove that the physician tried more conservative approaches first. In addition, Medicare won't cover PPH unless the prolapsed hemorrhoids are at least Grade III.

**Reporting Hemorrhoid Removal With Associated Procedures**
The physician will not always report hemorrhoidectomy by itself. He may perform other procedures, such as fissurectomy, fistulectomy, or fistulotomy, at the same time. When this occurs, your coding must adapt.

For example, you should report fissurectomy along with hemorrhoidectomy using either 46257 (Hemorrhoidectomy, internal and external, single column/group; with fissurectomy) or 46261 (Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy).

With the two codes now emphasizing on number of column(s)/group(s), you have to choose between a "single column/group" (46257) or "2 or more columns/groups" (46261) of hemorrhoidectomy.

Note: For fissurectomy without hemorrhoidectomy, report 46200 (Fissurectomy, including sphincterotomy, when performed). Fissurectomy is an increasingly uncommon procedure, and you will not likely report it often.

Include Hemorrhoidectomy With Fistulectomy

When reporting fistulectomy (either with or without fissurectomy) at the same time as hemorrhoidectomy, you should choose either 46258 (Hemorrhoidectomy, internal and external, single column/group; with fistulectomy, including fissurectomy, when performed) or 46262 (Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed).

Again, code selection depends on the number of columns / groups of hemorrhoids excised. CPT® has 4 separate codes to describe fistulectomy without fissurectomy:

46270 - Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous
46275 - Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric
46280 - Surgical treatment of anal fistula (fistulectomy/fistulotomy); transspincteric, supraspincteric, extraspincteric or multiple, including placement of seton, when performed
46285 - Surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage

Fistulectomy is a more involved procedure than fistulotomy and involves excising an anal fistula or passageway that forms when an infected crypt (or blind pit) drains to the skin. The physician may choose either to remove the fistula entirely (fistulectomy) or to remove only the ‘roof of the fistula (fistulotomy). Codes 46270-46285 are appropriate for fistulotomy as well as fistulectomy.

Report Sphincterotomy as a ‘Separate Procedure’

Be careful when reporting sphincterotomy (46080, Sphincterotomy, anal, division of sphincter [separate procedure]). CPT® classifies this as a “separate procedure,” so you cannot bill for it if the physician performs any related procedures, including hemorrhoidectomy.

In other words: You may report sphincterotomy only when it is the only procedure performed in the general anatomic area.

For example, if the physician excises three internal hemorrhoids by banding and performs a sphincterotomy at the same time, you may report only 46221 (Hemorrhoidectomy, internal, by rubber band ligation[s]) because the sphincterotomy is automatically included in any related procedure. If, however, the physician excises the hemorrhoids and then, several months later, returns to the operating room to perform only sphincterotomy for the same patient, you can report 46221 for the first surgery and 46080 for the second.
**E/M and Endoscopic Procedures With Hemorrhoidectomy**

When the physician evaluates a new patient or an established patient with a new problem, you may often report an appropriate-level E/M service and diagnostic scope(s) in addition to any hemorrhoid procedures.

**For instance:** The physician sees a new patient with rectal bleeding. She provides an E/M service that includes a history and exam to determine if the patient has a personal or family history of colon cancer, diverticulitis, or other problems. The physician also performs a diagnostic proctosigmoidoscopy (45300), or sigmoidoscopy (45330), or possibly even colonoscopy (45378) or an anoscopy (46600) to determine if a cause other than hemorrhoids is responsible for the bleeding.

The scopes reveal no problems in the rectum, sigmoid, or colon. The physician then ligates several hemorrhoids using rubber bands (46221).

**Hemorrhoids 101**

Hemorrhoids are a plexus of veins that returns the blood from the anus back to the heart for oxygenation. They are a normal part of the anatomy — everyone has hemorrhoids — which become a problem only when they are inflamed.

Clinicians classify hemorrhoids by grade, from least to most severe:

- **Grade I** hemorrhoids project into the anal canal and often bleed but do not prolapse (that is, bulge out beyond the anal verge).
- **Grade II** hemorrhoids may protrude beyond the anal verge with straining or defecating but reduce spontaneously when straining ceases.
- **Grade III** hemorrhoids protrude spontaneously or with straining and require manual reduction (that is, they have to be pushed back into the body).
- **Grade IV** hemorrhoids chronically prolapse and cannot be reduced. They usually contain both internal and external components (in other words, a "mixed" hemorrhoid) and may present with acute thrombosis or strangulation.

Classically, you find hemorrhoids in three locations — right posterior, right anterior, and left lateral — although you can find them at any position within the rectum.

**Internal vs. external hemorrhoids:** Internal hemorrhoids are those that occur proximal to the dentate line. External hemorrhoids occur distal to the dentate line. The dentate line is the interface between mucosa-lined intestine and squamous cell anal tissue. Internal hemorrhoids that protrude through the anus are prolapsed internal hemorrhoids, not internal and external.

In this case you may report the E/M service supported by the physician's documentation (for instance, 99203) and scopes in addition to the hemorrhoidectomy. You must, however, append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to the E/M service to differentiate it from the "inherent" E/M component of the other procedures (hemorrhoidectomy, scopes) provided on the same date. Therefore, your claim would read 46221 (for ligature hemorrhoidectomy), 9920x-25 (for the E/M service), and 45300 (for proctosigmoidoscopy), or 45330 (for sigmoidoscopy), or 45378 (for colonoscopy) depending upon the scope used during the procedure.

Be Careful: According to NCCI guidelines, you should not report both procedures 45300 (proctosigmoidoscopy) or 45330 (sigmoidoscopy) while you are reporting for colonoscopy (45378) on the same claim because both procedures are integral part of extensive procedure colonoscopy and can’t be billed in any circumstances. It contains "0" status indicator means you never unbundle the edit combination.

Had the patient in this example been established but with new symptoms of bleeding, the above also applies.
**Don’t Bill Scopes for Established Patients**

Typically, for established patients with known symptoms, you cannot claim scopes or E/M services in addition to rubber banding or other hemorrhoidectomy codes.

**For instance:** Physicians will often perform an anoscopy (46600) prior to hemorrhoidectomy. Check your latest version of CCI edits to find out if you can bill 46600 with 46221. So far, the codes have carried a ‘0’ status indicator, which implies you cannot bill them together under any circumstance.

**Example:** For a patient with a history of colon cancer (V10.05), the physician may choose to provide a separate scope to check for additional problems beyond hemorrhoids. But in most cases, you won’t get paid for more than rubber banding for an established patient, unless the physician clearly documents new and/or otherwise significant additional problems.

If the physician knows that surgery is necessary and chooses to forgo an extensive office examination, which can be painful for the patient, and instead examines the patient in the operating room after anesthesia, you may not report a separate E/M service.

**Warning:** Although the exam may be extensive, the service is not separately identifiable and did not affect the physician’s decision for surgery — in other words, the service does not meet the requirements for appending modifier 57 (Decision for surgery).

If the surgeon performs an anal exam under anesthesia, you may be able to report 45990 (Anorectal exam, surgical, requiring anesthesia [general, spinal or epidural], diagnostic). This is usually done in the OR when the patient’s pain doesn’t allow for an office examination, and must include perineal exam, anoscopy, and proctoscopy, according to CPT® instructions.

**Report Anorectal Fistula Repair with 46707**

Code 46707 (Repair of anorectal fistula with plug [e.g., porcine small intestine submucosa (SIS)]) should be your choice for reporting anorectal fistula repair.

Category III codes are important tracking mechanisms that often describe emerging technology, services, and procedures that aren’t yet listed under Category I.

**Benefit:** Although you should report a Category III code that accurately describes the service when there is no other option under the Category I codes, payment for Category III codes is often doubtful. That’s why having a new Category I code for the anorectal fistula plug repair may mean more money for your practice.

**Follow the Road Signs to Relocated Code**

The AMA also got a new method of relocating an existing out-of-order code. Rather than deleting the code and creating a new number with the same or similar definition, the AMA now moves the code to its more appropriate location and leaves a road sign for you. Where you would expect the code to be, AMA added references referring to the code’s new place.

**Example:** The definitions for hemorrhoid ligation and other anal excision procedures didn’t change much, but due to a restructuring of the entire anal excision section to introduce systematic procedure classification, the codes fit better after 46200 (Fissurectomy, including sphincterotomy, when performed). So the AMA lists codes for the section in the following order and adds # signs in front of codes that are out of numerical order:
- 46221 - Hemorrhoidectomy, internal, by rubber band ligation(s)
- # 46945 - Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group
- # 46946 - ... 2 or more hemorrhoid columns/groups
- # 46220 - Excision of single external papilla or tag, anus.
- 46230 - Excision of multiple external papillae or tags, anus
- # 46320 - Excision of thrombosed hemorrhoid, external.

Identifying out-of-sequence codes with # isn't the only guidance CPT® provides.

### Hemorrhoidectomy/Associated Procedure Quick Reference Chart

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Alone</th>
<th>Single Column/Group</th>
<th>Two or more Columns/Groups</th>
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<tr>
<td>Fissurectomy</td>
<td>46200</td>
<td>46257</td>
<td>46261</td>
</tr>
<tr>
<td>Fistulectomy/fistulotomy (with fissurectomy)</td>
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<td>46258</td>
<td>46262</td>
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<tr>
<td>Fistulectomy/fistulotomy (without fissurectomy)</td>
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<td>46258</td>
<td>46262</td>
</tr>
<tr>
<td>Sphincterotomy</td>
<td>46080</td>
<td>Included in primary procedure</td>
<td>Included in primary procedure</td>
</tr>
</tbody>
</table>

### Injections May Treat Anal Sphincter

As an alternative to sphincterotomy, the surgeon may treat the anal sphincter using Botox injections (46505, Chemodenervation of internal anal sphincter). The Botox prevents muscle spasm in the sphincter, allowing for healing.

To report Botox supplies, you should use HCPCS supply code J0585 (Injection, onabotulinumtoxinA, 1 unit) J0586 (Injection, abobotulinumtoxinA, 5 units) J0587 (Injection, rimabotulinumtoxinB, 100 units). Note that you will bill for Botox supplies only if your practice actually purchases and provides the drug. In many cases, the facility may provide the drug, or the insurer will pre-authorize the injection and supply the drug from its own pharmacy.

**Caution:** The Food and Drug Administration approves of two types or serotypes of botulinum, so you should keep the types separate for billing purposes. Specifically, J0587 (Injection, rimabotulinumtoxinB, 100 units), a drug trade named Myobloc, is not the same as Botox, or botulinum toxin type A. Do not use J0585 and J0587 interchangeably.

Under Medicare rules, you can receive reimbursement for wasted Botox simply by listing the amount of leftover drug on line 24G and appending modifier JW (Drug amount discarded/not administered to any patient) to indicate that the units listed in line 24G were not administered to a patient.

Medicare guidelines specifically state, "Both the amount of the agent administered and the amount discarded must be documented in the patient's medical record."

For each patient to receive Botox, the surgeon should document in block 24G of the CMS-1500 claim the exact number of units she provides. For the last patient to receive injections from a vial, you should also record the amount (in units) of wasted medication. Add the units injected to the number wasted, and report the total on the final claim.

**Example:** The surgeon opens a single 100-unit vial of Botox. She injects three patients with 30 units each. For the first two patients, you would list J0585 x 30 on line 24G of the claim form. For the final patient, you should list 30 units provided (J0585 x 30) and 10 units wasted (J0585-JW x 10), for a total of 40 units.