Chapter 35

Digestive System Procedures (40490-49999)

Chapter Outline

Learning Objectives

After completing this chapter, you should have the skills to:

35.1 Spell and define the key words, medical terms, and abbreviations related to digestive system procedures.
35.2 Discuss the types of digestive system procedures.
35.3 Identify the main characteristics of coding for the Digestive System.
35.4 Abstract procedural information from the medical record for coding digestive system procedures.
35.5 Assign codes for Digestive System procedures.
35.6 Arrange codes for Digestive System procedures
35.7 Code evaluation and management services for gastroenterology.
35.8 Discuss the CPT coding guidelines related to Digestive System.

Key Terms and Abbreviations

allotransplantation
anastomosis
by report
capsule endoscopy
incidental appendectomy
multiple endoscopy rule
proximal
pull-through
reducible
transnasal
transoral

In addition to the key terms listed here, students should know the terms defined within tables in this chapter.

For updates and corrections, visit our student resource site at

www.pearsonhighered.com/healthprofessionsresources

INTRODUCTION

It is exciting when a favorite store offers a BOGO sale—buy one, get one at half-price. Insurance companies require a similar discount when physicians bill for multiple procedures done at the same time. Coders indicate this circumstance with a modifier. Modifiers and multiple endoscopy payment rules are among the skills to be mastered when coding for the Digestive System.

DIGESTIVE SYSTEM PROCEDURE BASICS

Gastroenterology is a subspecialty of internal medicine that specializes in the digestive system. Gastroenterologists perform medical procedures such as endoscopies and gastric function studies, but they do not perform surgery. General surgeons perform surgery on digestive system organs and structures. Plastic surgeons perform reconstructive repairs involving the lips and mouth, such as cleft palate repair. Oral and maxillofacial surgeons (OMSs) also perform surgery on the face, mouth, and jaws.

For procedural purposes, the digestive system is divided into four parts:

- Upper gastrointestinal (GI) tract—lips through ileum
- Lower gastrointestinal (GI) tract—cecum through anus
- Accessory organs—salivary glands, liver, gallbladder, and pancreas
- Surrounding structures—abdomen, peritoneum, and omentum

Physicians use a variety of dividing points between the upper and lower GI tract, depending on the context:

- Diagnosis of bleeding—Bleeding above the duodenal junction is classified as upper GI bleeding, and bleeding below the duodenal junction is classified as lower GI bleeding.
- Endoscopic access—An upper GI endoscopy includes the mouth through the duodenum, and a lower GI endoscopy includes the cecum through the anus. The jejunum and ileum are not accessible to endoscopy procedures.
- Embryonic development—Developmentally, the GI tract is divided into three parts—the upper, from the mouth to the major duodenal papilla (*opening of the pancreatic duct into the duodenum*); middle, from the duodenal papilla to the mid-transverse colon; and lower, from the mid-transverse colon to the anus—based on the derivation from the foregut, midgut, and hindgut, respectively.

Because the digestive, or alimentary, tract consists of and connects several anatomic sites, medical terms frequently contain word roots of multiple sites, which are combined with a procedural suffix. To understand terminology, identify the suffix, then break down each word into the combining forms for each site. Refer to ■ TABLE 35-1 for a refresher on how to build medical terms related to digestive system procedures.

CODING CAUTION

Be alert for medical terms that are spelled similarly and have different meanings.

cholecystectomy (*excision of the gall bladder*) and **choledochocystectomy** (*excision of the common bile duct*)

laparotomy (*cutting into the abdomen*) and **laparoscopy** (*visual examination of the abdomen*)

an/o (combining form for *anus*) and **an-** (prefix meaning *none*)

Procedures commonly performed on each section of the digestive system are discussed next. Refer to detailed anatomic diagrams of specific parts of the digestive system when you need to refresh your memory of the relationship of organs and sites to each other.

Procedures of the Upper GI Tract

Procedures commonly performed on the upper GI tract are summarized in ■ TABLE 35-2 (pages 640–641). In particular, coders need to understand upper GI endoscopy, anastomosis, and foreign body removal.

Upper GI Endoscopy

Endoscopy is a procedure that is performed for screening, diagnostic, and therapeutic purposes. In the upper GI tract, the endoscope access can be **transoral** (*through the oral cavity*) or **transnasal** (*through the nose*) and can access the esophagus, stomach, and duodenum. Transnasal procedures are performed

Table 35-1 ■ **EXAMPLE OF CONSTRUCTING MEDICAL TERMS FOR DIGESTIVE SYSTEM PROCEDURES**

Root/Combining Form	Suffix	Complete Medical Term
esophag/o- (*esophagus*)	**-scopy** (*visual examination*) **-ectomy** (*excision*)	**esophago + scopy** (*visual examination of the esophagus*) **gastro + scopy** (*visual examination of the stomach*) **duodeno + scopy** (*visual examination of the duodenum*) **esophago + gastro + duodeno + scopy** (*visual examination of the esophagus, stomach, and duodenum*)
gastr/o (*stomach*)		**esophag + ectomy** (*excision of the esophagus*) **gastr + ectomy** (*excision of the stomach*)
duoden/o (*duodenum*)		**duoden + ectomy** (*excision of the duodenum*)

Source: © PB Resources, Inc. Used with permission.

Table 35-2 ■ **COMMON PROCEDURES OF THE UPPER GASTROINTESTINAL TRACT**

Procedure Name	Definition	Reason Performed
Antrectomy • Distal gastrectomy	The distal (*lowest*) portion of the stomach is excised. (Open)	Gastric ulcers, neoplasms
Billroth I • Gastroduodenostomy	The pylorus is removed and the **proximal** (*toward the center of the body*) stomach is anastomosed (*connected*) directly to the duodenum in an end-to-end manner. (Open)	Reestablish gastrointestinal continuity after excision of portions of one or more organs
Billroth II • Gastrojejunostomy	The greater curvature of the stomach is connected to the first part of the jejunum in a side-to-side manner. (Open)	Reestablish gastrointestinal continuity after excision of portions of one or more organs
Cleft lip/cleft palate repair	Abnormally oriented and attached muscles are repositioned to repair the functionality of soft palate musculature. (Open)	Cleft lip or cleft palate (*incomplete formation of the lip or roof of the mouth*)
Endoscopic balloon dilation (EBD)	Through-the-scope (TTS) balloon dilators or plastic dilators are moved over a guide wire to stretch the esophagus, pyloric valve, or duodenum. (Endoscopic)	Stricture (*narrowing*) of the esophagus, pylorus, or duodenum due to a variety of conditions (e.g., gastric outlet obstruction [GOO], peptic ulcers, Crohn's disease)
Endoscopic sclerotherapy	A solution that causes inflammation and scarring is injected into a vein to close it off. (Endoscopic)	Esophageal varices
Esophagectomy • Transhiatal esophagectomy (THE) • Transthoracic esophagectomy (TTE)	All or part of the esophagus is surgically removed. (Open)	Barrett esophagus, localized esophageal cancer
Esophagogastroduodenoscopy (EGD) • Upper gastrointestinal endoscopy	The endoscope is inserted through the mouth and moved down the throat into the esophagus, stomach, and duodenum. (Endoscopic)	Esophagitis, gastritis, gastroesophageal reflux disease (GERD), esophageal stricture (*narrowing*), varices, Barrett esophagus, hiatal hernia, ulcers, cancer
Foreign body removal (FBR)	An object is retrieved from within the body. (Endoscopic or open)	Removal of an object from outside the body that has made its way into the body, usually into a hollow organ, such as the nose, ear, or throat
Gastric bypass	The stomach is divided to create a small pouch and causes food to bypass part of the small intestine. (Laparoscopic or open)	Reduce calorie absorption
Heller myotomy • Esophagomyotomy	The esophageal sphincter muscle is cut. (Laparoscopic)	Achalasia (*a disorder of the esophagus that makes it difficult for foods and liquids to pass into the stomach*)
Laparoscopically adjustable gastric banding (LABG) • Lap-band • A-band • Gastric restriction	An inflatable silicone device is placed around the top portion of the stomach to divide it into a smaller pouch and a larger pouch. (Laparoscopic or open)	Slow and reduce food consumption
Nissen fundoplication	The upper part of the stomach is wrapped around the lower esophageal sphincter (LES). (Laparoscopic or open)	Strengthen the sphincter, prevent acid reflux, repair a hiatal hernia
Paraesophageal hernia repair • Hiatal hernia repair • Hiatus hernia repair • Fundoplication	The diaphragm is repaired using sutures or mesh; part of the stomach may be wrapped around the esophagus (fundoplication). (Laparoscopic or open)	Paraesophageal hernia (part of the stomach bulges through the hiatus [*opening in the diaphragm*])
Percutaneous endoscopic gastrostomy (PEG)	A tube is passed into a patient's stomach through the abdominal wall. (Percutaneous)	Feed patients who cannot swallow due to conditions such as stroke and neurological diseases

Table 35-2 ■ (*continued*)

Procedure Name	Definition	Reason Performed
Roux-en-Y (RNY) • Gastrojejunostomy	The stomach and small bowel are joined using an end-to-side anastomosis. (Laparoscopic or open)	Reestablish gastrointestinal continuity after excision of portions of one or more organs
Sialolithotomy	Calculus is removed from the salivary gland(s). (Open)	Sialolithiasis (*calculi in the salivary gland*)
Tonsillectomy/adenoidectomy (T&A)	The tonsils and adenoids are surgically removed. (Open)	Acute tonsillitis, obstructive sleep apnea, nasal airway obstruction, peritonsillar abscess
Vagotomy • Truncal vagotomy (TV) • Selective vagotomy (SV) • Highly selective vagotomy (HSV)	A portion of the vagus nerve in the stomach is excised. (Laparoscopic or open)	Peptic ulcer disease

Source: © PB Resources, Inc. Used with permission.

with a rigid endoscope. Transoral procedures can be performed with either a rigid or flexible endoscope. Rigid endoscopes provide excellent lighting and visualization and have tips of varying angles and sizes. They enable tissue collection, surgery, and procedures such as cauterization. Flexible endoscopes are smaller in diameter and can be manipulated in tight areas but require two hands to operate. Historically, flexible endoscopes have provided inferior lighting and images, but these have improved with the development of digital endoscopes. Among procedures most commonly performed with an endoscope are:

- collection of specimens by brushing or washing
- injections
- biopsies
- removal of foreign bodies
- dilation of strictures
- removal of tumors or polyps
- electrocauterization
- hemostasis
- ultrasound examination
- cyst drainage
- resection

Endoscopes cannot access the jejunum or ileum, so physicians may opt to use capsule endoscopy to examine the small intestine. **Capsule endoscopy** is a technology in which patients swallow a video capsule the size of a large pill that contains a video microchip, light bulb, battery, and radio transmitter. As the capsule moves through the alimentary tract, it takes about 14 photographs per second and transmits them to a receiver worn by the patient. When the capsule passes through the anus, it is flushed down the toilet. The physician downloads thousands of photographs from the receiver and analyzes them to formulate a diagnosis or plan for further testing.

Anastomosis

Sometimes all or part of a digestive organ must be removed because of disease. The excision interrupts the continuous flow of GI tract, so continuity is reestablished through anastomosis. **Anastomosis** is a surgical connection between two, usually tubular, structures such as the organs in the digestive tract or blood vessels. Several techniques can be used to join the structures:

- End-to-end—the ends of both tubes are connected
- End-to-side—the end of one tube is connected to an opening in the side of another
- Side-to-side—the sides of two tubes are connected with an opening between them

The choice of technique depends on the condition, the exact sites removed, and the surgeon's preference (■ FIGURE 35-1).

In an operative note, anastomosis can be described as a **pull-through**, which means that the surgeon removes the diseased portion of organ and connects the healthy segment to the adjacent organ. The pull-through procedure was originally developed to treat Hirschsprung disease (*nerve cells normally present in the wall of the intestine do not form properly during fetal development*). Part of the colon is excised, then joined to the anus in a posterior sagittal anorectoplasty (PSARP) procedure. The pull-through became preferred over a colostomy, and the technique was eventually adapted for use in other portions of the digestive tract.

SUCCESS STEP

An anastomosis is described with the suffix *-stomy* for the creation of a new opening and word roots that identify the two body parts joined. For example, *gastro/duodeno/stomy* describes the joining of the stomach and the duodenum.

Foreign Body Removal

Foreign bodies can enter the digestive tract through the mouth. They can pass through the system without incident or become lodged. Some objects, such as a coin, normally pass through without a problem and are excreted. An object that becomes lodged can create an obstruction or perforation and poses a medical risk.

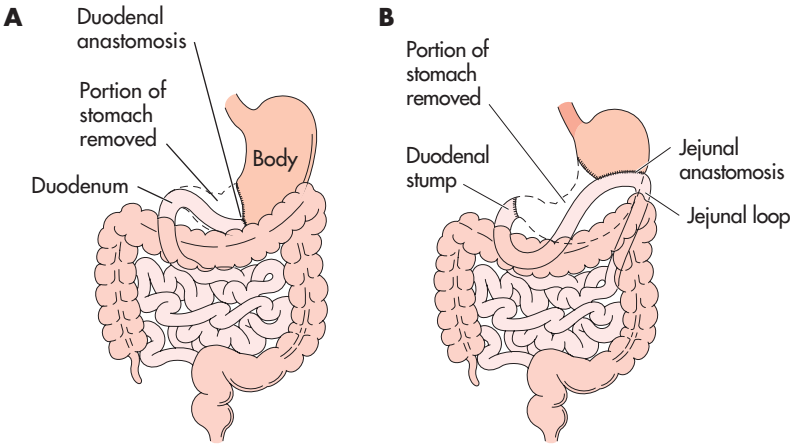

Figure 35-1 ■ Anastomoses. (A) End-to-End Gastroduodenostomy. (B) End-to-Side Gastrojejunostomy

Objects that are potentially poisonous must be removed immediately. For example, ingested batteries have potential for corrosive injury. X-rays are used to identify the type and location of foreign objects. Many can be retrieved endoscopically, but others require an open procedure to access the site.

Procedures of the Lower GI Tract

Procedures commonly performed on the lower GI tract are summarized in ■ TABLE 35-3. Endoscopy and ostomy procedures of the lower GI tract require special attention from coders.

Lower GI Endoscopy

Endoscopy of the lower GI tract is named after the sites examined: anoscopy (*endoscopy of the anus*), proctosigmoidoscopy (*endoscopy of the anus, rectum, and part of the descending colon*), sigmoidoscopy (*endoscopy of the anus, rectum, and part of the sigmoid colon*), and colonoscopy (*endoscopy of the entire colon from the rectum to the cecum and possibly the terminal ileum*). A colonoscopy is the preferred method of screening for colorectal cancer, which is recommended by the American Cancer Society and the Centers for Disease Control and Prevention (CDC)

Table 35-3 ■ **COMMON PROCEDURES OF THE LOWER GASTROINTESTINAL TRACT**

Procedure Name	Definition	Reason Performed
Appendectomy	Surgical removal of the appendix (Laparoscopic or open)	Appendicitis
Colectomy • Bowel resection • Total colectomy • Partial (subtotal) • Hemicolectomy • Proctocolectomy	Surgical removal of all or part of the large intestine (Laparoscopic or open)	Bleeding, bowel obstruction, Crohn's disease, colon cancer, ulcerative colitis, diverticulitis
Colonoscopy	Use of an endoscope to view the colon (*a thin, flexible tube with small video camera attached to take pictures or video*)	Ulcers, colon polyps, tumors, and areas of inflammation or bleeding; biopsy, screening for malignant neoplasm
Colostomy	Division (*cutting*) of the colon (*large intestine*), bringing the proximal end out through a stoma (*opening*) in the abdominal wall, bypassing the rectum and anus (Laparoscopic or open)	Bowel blockage (*obstruction*), bowel resection, injuries
Ileostomy • Enterostomy	Division of the ileum (*small intestine*) bringing the proximal end out to a stoma in the abdominal wall, bypassing the colon, rectum, and anus (Laparoscopic or open)	Inflammatory bowel disease, colon or rectal cancer, familial polyposis, birth defects involving the intestines, injuries
Polypectomy	Surgical removal of a polyp(s) (*abnormal growth from the mucous membrane*) (Laparoscopic or open)	Polyps
Small bowel transplant	Surgical removal of a diseased small intestine and replacement with some or all of a small intestine from a healthy person (Open)	Intestinal failure and complications related to parenteral nutrition (PN)

Source:

every 10 years from ages 50 to 75. When abnormalities are found by a screening colonoscopy, such as polyps that are removed, it becomes a therapeutic, or surgical, procedure.

Ostomy

An ostomy is a temporary or permanent surgically created opening that connects an internal organ to the surface of the body. In the lower GI tract, ostomies are performed most commonly to reroute the contents of the ileum or colon because of rectal cancer or inflammatory bowel disease. A temporary ostomy may be performed when the intestinal tract cannot be properly prepared for surgery, as occurs when it is blocked by disease (e.g., tumors) or scar tissue, or when inflammation or an operative wound needs to heal without contamination by stool. Temporary ostomies can usually be reversed with minimal or no loss of intestinal function. A permanent ostomy may be required when disease, or its treatment, impairs normal intestinal function or when the pelvic and anal sphincter muscles that control elimination do not work properly. After the procedure, an ostomy appliance (*a bag or pouch that is adhered to the body with an adhesive*) collects bowel contents. The appliance is quite secure and is emptied or changed as needed. Whenever a portion of the small or large intestines is removed, the excision procedure must be followed by an anastomosis or ostomy.

SUCCESS STEP

An ostomy is described with the word root of the organ involved and the suffix *-stomy* for the creation of a new opening. For example, *ileo/stomy* describes connecting the ileum to the abdominal wall, and *colo/stomy* describes connecting the colon to the abdominal wall.

Procedures of the Accessory Digestive Organs

Commonly performed procedures on the accessory digestive organs are summarized in ■ TABLE 35-4. In particular, coders need to be familiar with procedures on the biliary tract and transplant procedures.

Biliary Tract

The biliary tract, or biliary tree, consists of the gall bladder, cystic duct, common bile duct, extrahepatic ducts, and pancreatic duct (■ FIGURE 35-2, page 644). The sphincter of Oddi is a muscular valve that joins the biliary tree to the duodenum. Any of these structures can become inflamed or obstructed, requiring surgery that may involve multiple components. A cholecystectomy can be either a laparoscopic or open procedure. It can be

Table 35-4 ■ **COMMON PROCEDURES OF ACCESSORY DIGESTIVE ORGANS**

Procedure Name	Definition	Reason performed
Autologous islet cell transplantation	The pancreas is surgically removed and the islet cells are isolated then injected into the portal vein. (Open)	Prevent or minimize the risk of diabetes after a pancreatectomy
Cholecystectomy	Surgical removal of the gall bladder (Laparoscopic or open)	Gallstones, infected or inflamed gallbladder
Common bile duct (CBD) exploration	Injection of a dye into the duct, visualization on an X-ray, removal of calculi, and introduction of a drainage bag when necessary (Laparoscopic)	Obstructive jaundice, stones in bile ducts
Endoscopic retrograde cholangiopancreatography (ERCP)	Injection of contrast medium into the bile ducts via a tube through the ampulla of Vater to visualize the entire biliary tree (*pancreatic, common bile, cystic, and hepatic ducts*)	Obstructive jaundice, stones in bile ducts, pancreatitis, biliary strictures due to cancer
Hepatectomy • Liver resection	Surgical removal of all or part of the liver (Open)	Donor for, or recipient of, liver transplantation, usually due to neoplasms of the liver or cirrhosis
Lithotripsy of gallstones	Use of high-frequency sound waves to break up gallstones (External)	Cholelithiasis, choledocholithiasis
Liver biopsy	Surgical removal of a small piece of the liver (Percutaneous, transvenous, or laparoscopic)	Determine the presence of liver disease
Liver transplant	Surgical removal of a diseased liver and replacement with some or all of a healthy liver from another person (Open)	Acute and end-stage liver failure, usually due to neoplasms of the liver or cirrhosis
Pancreatectomy	Surgical removal of all or part of the pancreas (Open)	Chronic pancreatitis, malignant neoplasm
Pancreaticoduodenectomy • Whipple procedure	Surgical removal of parts of the pancreas, duodenum, common bile duct, and, if required, portions of the stomach (Open)	Pancreatic cancer, neuroendocrine (islet cell) tumors, chronic pancreatitis, cancer of the ampulla of Vater (ampullary cancer), duodenal cancer, cancer of the distal bile duct

Source:

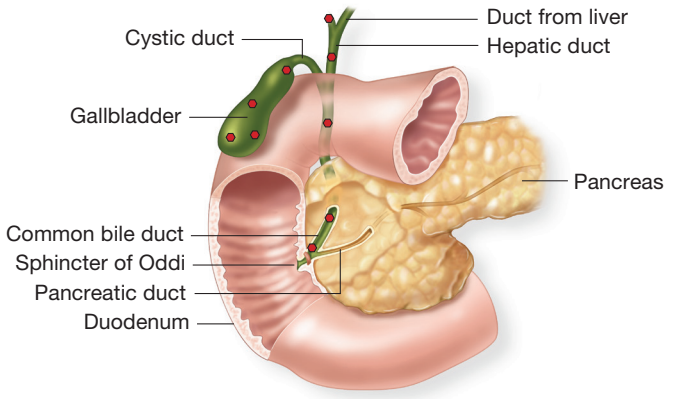

Figure 35-2 ■ Biliary Tract. (Red Dots Identify Common Sites of Calculi.)

performed alone, aided by cholangiography, with exploration and/or excision of the common bile duct, with anastomosis of the intestinal tract, and with a sphincteroplasty or sphincterotomy. Calculi can occur in the gall bladder, common bile duct, or both. When gallstones become symptomatic, they must be excised or destroyed using a method such as lithotripsy.

Transplantation

The liver and pancreas are two of the six organs that can be transplanted between individuals. Organ transplantation involves three distinct components: harvesting the donor organ, backbench work to prepare the organ, and recipient **allotransplantation** (*receiving an organ from another person*).

Liver transplantation is the replacement of a diseased liver with some or all of a healthy liver from another person. It is a viable treatment option for acute liver failure and end-stage liver disease, which can be caused by cirrhosis (*scarring of the liver*), chronic hepatitis B or C, bile duct diseases, genetic diseases, autoimmune liver diseases, primary liver cancer, alcoholic liver disease, and fatty liver disease.

Surgeons remove the diseased liver and replace it with the donor organ in the same anatomic location. The donor organ usually comes from a cadaver, but recent advances in transplant medicine now make it possible for living donors to donate a portion of their liver. Typically, the right lobe of the donor's liver is removed. The liver begins to regenerate almost immediately and continues to do so for about a year.

Although all transplants are complicated procedures, liver transplants are even more intricate because of the number of disconnections and reconnections of abdominal and hepatic tissue and blood vessels. A liver transplant typically requires 4 to 12 hours and three surgeons, two anesthesiologists, and up to four nurses.

Pancreas transplants are provided for diabetic patients, often in conjunction with a kidney transplant. The diseased pancreas is not removed during the operation. The donor pancreas is usually placed in the right lower part of the patient's abdomen. Blood vessels from the new pancreas are anastomosed to the patient's blood vessels. The donor duodenum, if retained, is anastomosed to the patient's intestine or bladder. Pancreas transplant surgery takes about 3 hours; a combination kidney/pancreas transplant requires about 6 hours.

Pancreatic islets, also called islets of Langerhans, are tiny clusters of cells scattered throughout the pancreas. Autologous (*from the same person*) islet cell transplantation is an option for patients who require a pancreatectomy because of chronic pancreatitis that cannot be managed by other treatments. The surgeon removes the pancreas from the patient, extracts and purifies islets, and infuses them into the patient's liver using a catheter. The goal is to give the body enough healthy islets to make insulin. Type 1 diabetics cannot receive autologous islet cell transplants because their beta cells (*islet cells that produce insulin*) do not function. Allotransplantation from a cadaver is an experimental procedure approved for limited use by the Food and Drug Administration (FDA) and is being tested as an option for type 1 diabetics.

SUCCESS STEP

The six organs that can be transplanted are, in descending order of frequency, kidney, liver, heart, lung, pancreas, and intestine.

Procedures of the Abdominal Structures

Procedures commonly performed on the abdominal structures that surround the digestive organs are summarized in ■ TABLE 35-5. When extensive adhesions impede access to an intended operative site, surgeons must perform adhesiolysis as part of the procedure.

Hernias can occur in several locations and are named by site (■ FIGURE 35-3). Some hernias are **reducible**, which means they can be corrected by the physician pushing the tissue back into place, whereas others require surgical repair, suturing, or insertion of a mesh prosthesis to reinforce the abdominal wall.

This section provides a general reference to help understand the most common digestive system procedures. Remember to keep standard reference books handy in case you get stuck.

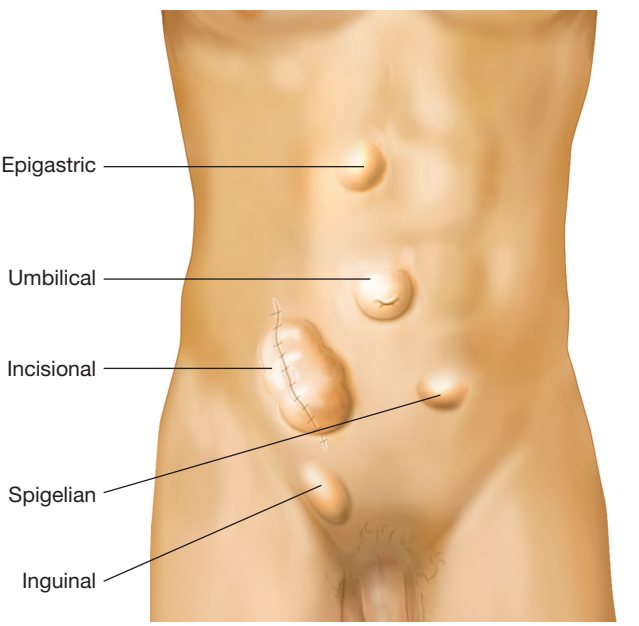

Figure 35-3 ■ Common Types of Hernias

Table 35-5 ■ **COMMON PROCEDURES WITHIN THE ABDOMINAL CAVITY**

Procedure Name	Definition	Reason Performed
Adhesiolysis	Use of scalpel or electric current to destroy or cut free adhesions (*scar tissue between organs or structures*) (Laparoscopic or open)	Abdominal adhesions
Hernia repair • Hernioplasty • Herniorrhaphy • Herniotomy	Surgical correction of a hernia through the use of manual manipulation, sutures, or mesh (External, laparoscopic, or open)	Bulging of internal organs or tissues through a defect in the wall of a body cavity
Omental flap	Removal of part of the omentum with blood vessel supply intact (Open)	Reconstruction of other anatomic sites, such as the chest wall or abdomen
Paracentesis	A surgical puncture of a body cavity to remove ascites (*excess fluid*) (Percutaneous)	Remove excess fluid caused by conditions such as infection, inflammation, cirrhosis, cancer, or injuries.

Source: © PB Resources, Inc. Used with permission.

CODING PRACTICE

Exercise 35.1 Digestive System Procedure Basics

Instructions: Use your medical terminology skills and resources to define the following procedures, then identify the applicable code or code range. Follow these steps:

- Use slash marks "/" to break down the underlined term into its root(s) and suffix.
- Define the meaning of the underlined word based on the meaning of each word part.
- Use the entire phrase to identify the code(s) or code range shown in the CPT Index.

Example: appendectomy, laparoscopic
append/ectomy — Meaning *cutting out of the appendix* — CPT Code *44970*

1. Operculectomy — Meaning _____ — CPT Code _____
2. Pancreatorrhaphy — Meaning _____ — CPT Code _____
3. Sialodochoplasty — Meaning _____ — CPT Code _____
4. Anus, sphincter, sphincterectomy — Meaning _____ — CPT Code _____
5. Proctosigmoidoscopy, biopsy — Meaning _____ — CPT Code _____
6. Cholangiopancreatography, endoscopic retrograde, with papillotomy — Meaning _____ — CPT Code _____
7. Vermilionectomy — Meaning _____ — CPT Code _____
8. Pyloromyotomy — Meaning _____ — CPT Code _____
9. Enterolysis — Meaning _____ — CPT Code _____
10. Cheiloplasty — Meaning _____ — CPT Code _____

CODING OVERVIEW OF DIGESTIVE SYSTEM PROCEDURES

The CPT Surgery subsection **Digestive System (40490-49999)** contains 18 subheadings divided by anatomic site. Anatomic sites are arranged by the order in which they occur in the alimentary (*digestive*) tract, beginning with the lips and ending with the anus. The last four subheadings identify sites that aid in digestion but are not part of the alimentary tract: the liver; biliary tract; pancreas; and abdomen, peritoneum, and omentum. Each subheading contains categories divided by the type of procedure, such as incision, excision, introduction, endoscopy, destruction, repair, and other procedures. The specific category titles vary by subheading based on what is applicable to a particular anatomic site. Review the subheadings, categories, and code ranges listed at the beginning of the Digestive System subsection in

many CPT manuals, to become familiar with the content and organization.

This chapter includes invasive, minimally invasive, and noninvasive surgical procedures on the digestive system. Codes for diagnostic tests on the digestive system appear in the Medicine section. The medical necessity of any procedure codes always must be supported by diagnosis codes. CPT codes in the Digestive System subsection are frequently supported by diagnosis codes from ICD-10-CM **Chapter 11 Diseases of the Digestive System (K00-K95)**, as well as neoplasms, symptoms and signs, and injuries (■ TABLE 35-6). ICD-10-CM classifies injuries of the lips, mouth, and tongue with injuries of the face. Injuries of the throat are classified with injuries of the neck. These are the most commonly used codes to support procedures on the digestive system; however, diagnosis codes from any ICD-10-CM chapter are permissible.

CPT guidelines at the beginning of the Surgery section apply to Digestive System procedures. There are no special instructions at the beginning of this subsection, but there are some for subheadings and categories that provide definitions and coding information. A special instruction that appears in each endoscopy or laparoscopy category is that a surgical endoscopy or laparoscopy always includes a diagnostic endoscopy or laparoscopy. To report a diagnostic laparoscopy as a separate procedure, use code **49320**. Instructional notes appear throughout the Tabular List to alert coders to the need for modifiers, provide cross-references to codes for similar procedures on other sites, identify when additional codes might be needed for radiological services, and highlight resequenced and recently deleted codes.

Table 35-6 ■ **LOCATING ICD-10-CM AND ADDITIONAL CPT CODES FOR THE DIGESTIVE SYSTEM**

Type of Code	Codes
ICD-10-CM Digestive System-Related Codes	
Digestive system conditions	**K00-K95**
Neoplasms	**C00-C26**
Symptoms and signs	**R10-R19**
Injuries	**S09.93, S19.9, S36.-, T28.-**
CPT Digestive System-Related Codes	
Medicine procedures	**91010-91299**
Radiologic procedures	
• Diagnostic radiology	**74210-74363**
• Diagnostic ultrasound	**76700-76766, 76975**
• Radiologic guidance	**77001-77022**
• Nuclear medicine, diagnostic	**78201-78299**
Laboratory organ/disease panels	**80074-80076**

Source: © PB Resources, Inc. Used with permission.

ABSTRACTING DIGESTIVE SYSTEM PROCEDURES

Abstracting digestive system procedures requires paying special attention to the detailed anatomy of the digestive system and the order of the digestive organ within the GI tract, starting from either end. Knowledge of the order of the alimentary tract is necessary to determine the path of an endoscope and the farther site reached. Refer to Chapter 9 in this text for a refresher on digestive system anatomy.

In addition to familiarity with each structure, coders must be able to locate specific anatomic landmarks within the mouth, salivary glands, stomach (■ FIGURE 35-4), or colon. Coders need to read operative or procedure reports and determine the exact organ(s) and site(s) accessed, treated, excised, and/or reconnected to another site.

Refer to ■ TABLE 35-7 for guidance on how to abstract procedures on the Digestive System, then work through the detailed example that follows. Remember that the abstracting questions are a guide and that not every question applies to, or can be answered for, every case. For example, anastomosis is not performed in every procedure. Age is a factor for tonsillectomies and some hernia repairs.

Guided Example of Abstracting Digestive System Procedures

Refer to the following example throughout this chapter to practice skills for abstracting, assigning, and arranging Digestive System procedure codes.

Table 35-7 ■ **KEY CRITERIA FOR ABSTRACTING DIGESTIVE SYSTEM PROCEDURES**

- ❑ What is the patient's age?
- ❑ What site(s) is treated?
- ❑ What primary procedure is performed?
- ❑ What other procedure(s), if any, are performed?
- ❑ Is the treatment screening, diagnostic, or therapeutic?
- ❑ What is the approach?
- ❑ What exact sites within an organ are excised or treated?
- ❑ What type of anastomosis, if any, is performed?
- ❑ What sites are joined in the anastomosis?

Endoscopy

- ❑ What approach (access) is used?
- ❑ What is the farthest site reached?
- ❑ Is the purpose of the service preventive care?
- ❑ Does a screening or diagnostic endoscopy convert to a therapeutic procedure?
- ❑ Is the endoscopy a separate procedure?
- ❑ Was more than one treatment performed during the endoscopy?
- ❑ Is the patient covered by Medicare?

Source: © PB Resources, Inc. Used with permission.

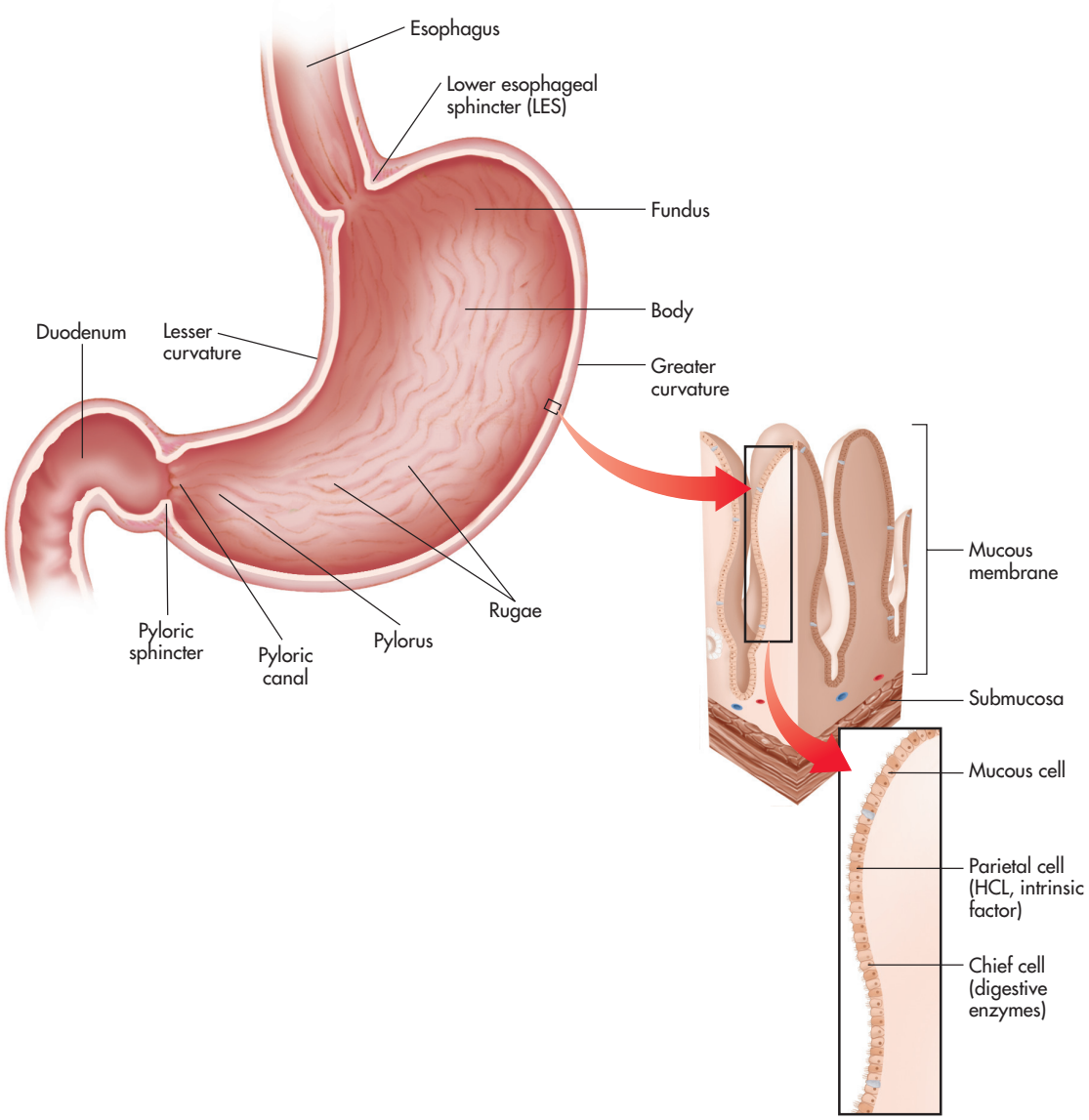

Figure 35-4 ■ Anatomic Landmarks of the Stomach

OUTPATIENT HOSPITAL Gender: M Age: 57

Preoperative diagnosis: hematochezia

Procedure: Colonoscopy, polypectomy, hemorrhoidectomy. Inspection of anus immediately revealed internal hemorrhoids. Colonoscopic examination identified 2 polyps in the sigmoid colon at 20 cm that were removed with hot forceps and one polyp in the transverse colon at 100 cm that was removed with a snare. Remainder of colon to cecum was unremarkable. Hemorrhoids were ligated with rubber bands. Patient tolerated procedure well and was transferred to the recovery area. Polyps were submitted to pathology.

Postoperative diagnosis: internal first-degree hemorrhoids, colonic polyps

Pathology report: benign adenomatous polyps

Follow along as fictitious coder Jill Hynes, CPC, abstracts the procedure. Check off each step after you complete it.

▶ Jill reads through the entire record, paying special attention to the reason for the encounter, the procedure performed, and the postoperative diagnosis. She refers to the Key Criteria for Abstracting Digestive System Procedures (Table 35-7).

- ❑ She notes the preoperative diagnosis, hematochezia (*bloody stool*).
- ❑ *What is the patient's age?* 57
- ❑ *What site is treated?* colon
- ❑ *What primary procedure is performed?* colonoscopy
- ❑ *What other procedure(s), if any, are performed?* polypectomy, hemorrhoidectomy
- ❑ *Is the treatment screening, diagnostic, or therapeutic?* diagnostic because of hematochezia

- ❑ *What is the approach?* through the anal opening
- ❑ *What exact sites within an organ are excised or treated?* anus, sigmoid colon, transverse colon
- ❑ *What is the farthest site reached?* cecum
- ❑ *Is the purpose of the service preventive care?* No
- ❑ *Does a screening or diagnostic endoscopy convert to a therapeutic procedure?* Yes, polyps were removed.
- ❑ *Is the endoscopy a separate procedure?* Yes, because no other procedures were performed.
- ❑ *Was more than one treatment performed during the endoscopy?* Yes, two methods of polyp removal: hot forceps and snare

▶ At this time, Jill does not know which of these procedures may need to be coded, nor how many codes she will end up with. She will learn about this when she moves on to assigning codes.

CODING PRACTICE

Exercise 35.2 Abstracting Digestive System Procedures

Instructions: Read the mini-medical-record of each patient's encounter and answer the abstracting questions. Write the answer on the line provided. Do not assign any codes.

1. OUTPATIENT HOSPITAL Gender: M Age: 57

Preprocedure diagnosis: screening colonoscopy

Procedure: flexible colonoscopy, two polyps in descending segment, one polyp in transverse segment, remainder of colon to cecum was clear. Polyps were removed with bipolar cautery and submitted to pathology

Postprocedure diagnosis: adenomatous polyps per pathology report

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

c. What approach (access) is used? _____

d. What is the farthest site reached? _____

e. Is the purpose of the service preventive care? _____

f. Does a screening or diagnostic endoscopy convert to a therapeutic procedure? _____

g. Is the endoscopy a separate procedure? _____

h. Was more than one treatment performed during the endoscopy? _____

2. INPATIENT HOSPITAL Gender: F Age: 33

Diagnosis: morbid obesity, BMI = 43 kg/m^2

Procedure: laparoscopic gastric bypass and Roux-en-Y gastroenterostomy (100 cm)

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

c. What other procedure(s), if any, are performed?

_____

(*continued*)

2. (continued)

d. Is the treatment screening, diagnostic, or therapeutic?

_____

e. What is the approach? _____

f. What exact sites within an organ are excised or treated?

_____

g. What type of anastomosis, if any, is performed?

_____

h. What sites are joined in the anastomosis? _____

3. INPATIENT HOSPITAL Gender: F Age: 48

Diagnosis: squamous cell carcinoma of the esophagus

Procedure: near-total esophagectomy, thoracotomy, end-to-side pharyngogastrostomy (*restructuring of the pathway from the throat to the stomach after esophagectomy*)

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

c. What other procedure(s), if any, are performed?

_____

d. Is the treatment screening, diagnostic, or therapeutic?

_____

e. What is the approach? _____

f. What exact sites within an organ are excised or treated?

_____

g. What type of anastomosis, if any, is performed?

_____

h. What sites are joined in the anastomosis? _____

4. OUTPATIENT HOSPITAL Gender: M Age: 64

Diagnosis: initial incarcerated incisional hernia

Procedure: incarcerated incisional hernia repair with mesh

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

(*continued*)

4. (continued)

c. What other procedure(s), if any, are performed?

_____

d. Is the treatment screening, diagnostic, or therapeutic?

_____

e. What is the approach? _____

5. OUTPATIENT HOSPITAL Gender: M Age: 61

Preoperative diagnosis: melena, hematemesis

Procedure: EGD was initiated with flexible scope through the mouth. Identified bleeding ulcers in esophagus and duodenum, which were successfully cauterized. Features of chronic gastritis were noted. No masses or hiatal hernia. Obtained biopsy from the antrum. Biopsies submitted to pathology for H&E (*hematoxylin and eosin stain test to detect cancer*) and CLO (Campylobacter-*like organism test for* H. pylori).

Postoperative diagnosis: bleeding esophageal ulcer and bleeding peptic ulcer

Pathology report: biopsies negative for *H. pylori* and carcinoma

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

(*continued*)

5. (continued)

c. What is the approach? _____

d. What is the farthest site reached? _____

e. Does a screening or diagnostic endoscopy convert to a therapeutic procedure? _____

f. Was more than one treatment performed during the endoscopy? _____ If so, name the additional procedures. _____

6. INPATIENT HOSPITAL Gender: M Age: 3 months

Diagnosis: bilateral cleft lip and nasal deformity

Procedure: primary repair of a bilateral cleft lip and nasal deformity; repair of soft tissue of cleft palate and closure of alveolar ridge

a. What site(s) is treated? _____

b. What primary procedure is performed? _____

c. What other procedure(s), if any, are performed?

_____

d. Is the treatment screening, diagnostic, or therapeutic?

_____

e. What is the approach? _____

f. What exact sites within an organ are excised or treated?

_____

ASSIGNING CODES FOR DIGESTIVE SYSTEM PROCEDURES

This section reviews coding rules for several commonly performed Digestive System procedures: tonsillectomy, appendectomy, anastomosis, endoscopy, transplants, and repairs. Learning about these procedures will reinforce basic coding skills that you can use throughout the CPT manual.

Tonsillectomy

Tonsillectomy and adenoidectomy (**42820-42870**) provide several coding options based on patient age and the combination of procedures performed. Codes *do not* distinguish among the surgical method used: tonsillotome (*scalpel*), cryosurgery, laser, or electrocautery.

To assign codes, search the Index for the Main Term **Tonsillectomy**; **Tonsils** with the first-level modifying term **Excision**; or **Adenoids** with the first-level modifying term **Excision**. Review and verify the codes in the Tabular List based on the following criteria.

When a tonsillectomy and adenoidectomy are performed together, select the code based on patient age: **42820** for **younger than 12** and **42821** for **age 12 or over**.

When only a tonsillectomy is performed, select the code based on patient age: **42825** for **younger than 12** and **42826** for **age 12 or over**.

When only an adenoidectomy is performed, determine whether the procedure is primary (*the patient's first adenoidectomy*) or secondary (*the patient's second adenoidectomy performed to remove regrowth after a previous surgery*). Then select the code based on the patient's age. Codes **42830** and **42831** identify a primary adenoidectomy; codes **42835** and **42836** identify a secondary adenoidectomy.

Codes for other tonsil procedures, such as radical resection, excision of tonsil tags, and excision of the lingual tonsil, also are provided.

SUCCESS STEP

When you see the term *tonsil*, be sure to identify the anatomic site of the tissue. *Tonsil* refers to a small rounded mass of lymphoid tissue. The palatine (*pertaining to the palate*) tonsils are located at the back of the throat and are commonly referred to simply as tonsils. There are several other sites of tonsil tissue throughout the mouth and throat, and there is even tonsil tissue in the cerebellum.

Appendectomy

Although there are only six codes in the Appendix subheading, they are used frequently, and coders must understand the differences. To locate codes in the Index, search for the Main Term **Appendix** or **Appendectomy**. In the Tabular List, CPT provides one code for **Incision and drainage of appendiceal abscess, open** (**44900**), three codes for open appendectomies, and one code for a laparoscopic appendectomy (plus a code for an unlisted laparoscopic procedure).

An **incidental appendectomy** is the removal of the appendix as a preventive measure during another procedure, such as a cholecystectomy. Incidental appendectomies are usually not coded.

When an appendectomy is performed for an indicated (specific) reason, assign the code as follows. Refer to the CPT manual to observe the formatting of codes and read the full code descriptions.

- When an open appendectomy is performed and the appendix has not ruptured, assign **44950**.
- When an open appendectomy is performed for a ruptured appendix with abscess or generalized peritonitis, assign **44960**.
- When an open appendectomy is done for an indicated reason at the same time as another procedure, assign the add-on code **44955**.
- For a laparoscopic appendectomy, assign **44970**.

Anastomosis

Anastomosis is not a standalone procedure; it is performed in conjunction with a total or partial excision of an organ. When an excision is performed on the alimentary tube or a duct, either an anastomosis or an ostomy is almost always necessary.

To locate codes in the Index, search for the Main Term **Anastomosis**, a first-level modifying term for the site treated, and a second-level modifying term for the site connected to.

Refer to the Tabular List to select the correct code based on the details of the procedure. Read the code options to determine how anastomosis is to be coded:

- bundled into the code for the main procedure
- an indented code under the main code
- an add-on code
- a separate standalone code

Identify the two sites that are connected and the type of connection created, such as Roux-en-Y, end to end, end to side, and side to end. The specific type of connection is sometimes, but not always, coded.

Endoscopy

CPT differentiates between endoscopy and laparoscopy in the Digestive System subsection. Endoscopy codes describe access through the mouth, nose, or rectum. Laparoscopy codes describe percutaneous access through the abdomen. The subheadings Esophagus and Intestines provide codes for both endoscopy and laparoscopy. The subheading Anus provides endoscopy codes only. The subheadings Stomach; Appendix; Liver; and Abdomen, Peritoneum, and Omentum provide laparoscopy codes only because these sites, except for the stomach, cannot be reached endoscopically. Endoscopy of the stomach and duodenum is classified with the esophagus because the stomach and duodenum are examined in conjunction with the esophagus.

Each category for endoscopy or laparoscopy presents special instructions that define the extent of the examinations for the respective anatomic sites. The special instructions also direct that a surgical scope procedure always includes a diagnostic scope procedure. This instruction means that when an endoscopic or laparoscopic procedure begins as a screening or diagnostic procedure and is converted to a surgical procedure, only the surgical procedure should be coded.

For example, during a screening colonoscopy, the physician may remove a polyp. The polypectomy coverts the procedure from screening to surgical, but only one code—the one for the polypectomy—should be reported.

Assign endoscopy codes based on the farthest site accessed. In the upper GI system, when the esophagus, stomach, and duodenum are examined, assign a code for esophagogastroduodenoscopy only; do not also assign a code for esophagoscopy. In the lower GI system, when the entire colon is examined, assign a code for colonoscopy only; do not also assign codes for anoscopy, proctosigmoidoscopy, and sigmoidoscopy, even if procedures were done in those areas (■ FIGURE 35-5).

Multiple Endoscopy Rule

The **multiple endoscopy rule** explains how to assign endoscopy codes when more than one procedure is performed during the same session. Endoscopy codes are divided into families, each with a base code. The base code is a screening/diagnostic endoscopy for a particular region. The other codes in the family are therapeutic/surgical procedures, such as biopsy, dilation, or tumor excision. You may assign as many surgical codes from one family as necessary, but do not assign the *base* diagnostic endoscopy code together with a *surgical* endoscopy code. The Medicare Physician Fee Schedule Database (MPFSDB) identifies the codes subject to this rule and the corresponding base codes (■ TABLE 35-8). The descriptions of the base codes include the designation **(separate procedure)**, which means that the base code should be reported only when it is done as a distinct procedure and not as part of a more extensive surgical procedure. Each code in the family includes the work RVU and price of the base code service, plus the additional work and price for the surgical procedure. Although more than one surgical endoscopy code from the same family can be billed, a special endoscopy payment formula excludes the price of the base service from all but the first code reported (■ FIGURE 35-6, page 652).

Upper GI Endoscopy

CPT provides endoscopy codes for esophagoscopy and esophagogastroduodenoscopy. Special instructions at the beginning of the Endoscopy category define an esophagoscopy as extending

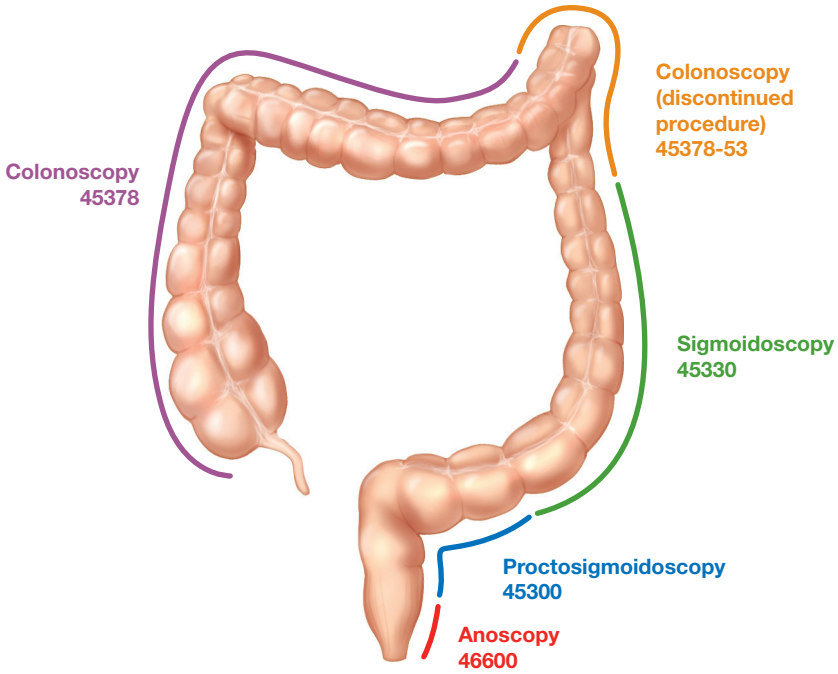

Figure 35-5 ■ Lower GI Endoscopy Codes

from the upper esophageal sphincter to the gastroesophageal junction. When only the esophagus is examined, assign a code for esophagoscopy (**43191-43232**). Esophagoscopy codes are divided based on whether the endoscope is rigid (parent code **43191**) or flexible. Flexible endoscopy codes are divided based on whether the access is transnasal (parent code **43197**) or transoral (parent code **43200**). Each of these code families is subdivided based on the additional procedures performed during the examination, such as a biopsy, foreign body removal, or polyp removal.

When the stomach and duodenum are examined, assign a code for esophagogastroduodenoscopy (**43235-43259**). Do not

Table 35-8 ■ **ENDOSCOPIC CODE FAMILIES FOR THE DIGESTIVE SYSTEM**

Base Code	Short Description	Code Family
43191	Esophagoscopy, rigid, transoral; diagnostic	43192-43196
43197	Esophagoscopy, flexible, transnasal; diagnostic	43198
43200	Esophagoscopy, flexible, transoral; diagnostic	43201-43232
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic	43233-43259, 43270
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic	43261- 43265, 43274-43278
44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic	44361-44373
44376	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic	44377-44379
44388	Colonoscopy through stoma; diagnostic	44389-44397
45300	Proctosigmoidoscopy, rigid; diagnostic	45303-45327
45330	Sigmoidoscopy, flexible; diagnostic	45331-45345
45378	Colonoscopy, flexible; diagnostic	45379-45392
46600	Anoscopy; diagnostic	46604-46615
47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic	47553-47556
49320	Laparoscopy, abdomen, peritoneum, and omentum; diagnostic	49321-49325

Patient underwent a flexible transoral esophagoscopy because of bleeding. A biopsy was taken and band ligation of esophageal varices was performed.

43205 Esophagoscopy, flexible, transoral; with band ligation of esophageal varices facility
43202-59 Esophagoscopy, flexible, transoral; with biopsy, single or multiple facility;
-59 Separate procedure

Multiple Endoscopy Payment Calculation

Code	MPFS RVU	MPFS facility fee	Payment rule	Medicare allowable
Endoscopic base code 43200	2.71	$97.08	Do not bill the base code (diagnostic) when therapeutic procedures from the same endoscopy family are performed.	The endoscopic base code is used for reference. It is not billed because therapeutic procedures from the same endoscopy family were performed.
43205	4.34	$155.47	Pay (allow) the first endoscopy at 100%	$155.47
43202	3.19	$114.27	Subtract the price of the base code from the second and subsequent codes in the same endoscopy family.	$114.27 - 97.08 = $17.29
			Total	$172.76

Figure 35-6 ■ Example of Multiple Endoscopy Payment Rule. *Source: © PB Resources, Inc. Used with permission. CPT codes only © American Medical Association.*

also assign a code for esophagoscopy because the service is included in the code for the esophagogastroduodenoscopy. Code **43235** is the parent code for this code family. Codes are divided based on the additional procedures performed during the examination. CPT provides an important instructional note at the beginning of the esophagogastroduodenoscopy code family. When the examination includes the stomach but not the duodenum, assign a code for esophagogastroduodenoscopy with modifier **-52** or **-53**. The choice of modifier depends on whether the physician intends to repeat the examination to include the duodenum.

- When the duodenum is not examined because it is not considered clinically relevant to the reason for the procedure, assign modifier **-52 Reduced services** (■ FIGURE 35-7).
- When the duodenum is not examined because an issue, such as retained gastric contents, prevents safe access to the duodenum, and the physician plans to repeat the procedure under better conditions, assign modifier **-53 Discontinued procedure** (■ FIGURE 35-8).
- When a repeat examination is not planned, assign modifier **-52 Reduced services**.

CODING CAUTION

Many codes in the Digestive System have been resequenced. The cross-referencing instruction provided in the Tabular List does not always lead to the exact location of the resequenced code. It is worthwhile to take a few minutes to locate the new code, then write a note next to where the code number appears in numerical order. For example, the cross-reference next to code **46945** states **See 46200-46288.** Because this is a large range to search, next to **46945** write *see after code 46221* so you can immediately locate the resequenced code.

Patient underwent an endoscopic examination of the esophagus and stomach because of suspected reflux disease. The physician does not examine the duodenum because it is not clinically pertinent.

43235-52 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure); -52 Reduced services

Figure 35-7 ■ Example of Coding an EGD with Modifier -52

Patient underwent an esophagogastroduodenoscopy for peptic ulcers. The physician cannot move the endoscope past the gastroduodenal junction because the patient did not prepare properly and there is still food in the duodenum. The patient is instructed about the necessity of proper preparation. The procedure is rescheduled for next week.

43235-53 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure); -53 Discontinued procedure

Figure 35-8 ■ Example of Coding an EGD with Modifier -53

Table 35-9 ■ **HCPCS LEVEL II CODES FOR COLON CANCER SCREENING**

HCPCS Code	HCPCS Code Descriptor
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
G0107	Colon cancer screening; FOBT, 1–3 simultaneous determinations
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122	Colon cancer screening; barium enema (noncovered)
G0328	Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1–3 simultaneous determinations

Source: Centers for Medicare and Medicaid

Medicare Colonoscopy Coding

Medicare has special rules for coding screening colonoscopies. The code for a screening colonoscopy for non-Medicare patients is **45378**. Medicare requires that a HCPCS Level II code be used. **G0105** identifies a screening for an individual at high risk of developing colon cancer, which Medicare has established specific criteria for. **G0121** is used for a screening colonoscopy for a person who does not meet Medicare's high-risk criteria. Medicare also provides HCPCS Level II codes for other types of colorectal cancer screening: fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening barium enema (■ TABLE 35-9). Medicare provides detailed instructions regarding how these codes should be used and the diagnoses needed to support them.

When a screening colonoscopy is converted to a diagnostic or surgical endoscopy—for example, when polyps are removed—assign the HCPCS Level II modifier **-PT Colorectal cancer screening test, converted to diagnostic test or other procedure** (■ FIGURE 35-9).

Physician performs a screening colonoscopy on a patient not at high risk. During the procedure, two polyps were found and removed using hot forceps.

G0121-PT Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk; -PT Colorectal cancer screening test, converted to diagnostic test or other procedure

Figure 35-9 ■ Example of Coding for a Medicare Screening Colonoscopy

Transplants

Each type or organ transplant has three groups of codes for the three main parts of the transplant process: donor organ harvesting, backbench work, and recipient transplantation. Special instructions at the beginning of each transplant category (liver, pancreas, and small intestine) describe the division and use of codes.

For liver transplants, different codes are used for a cadaver hepatectomy (**47133**) than for a living donor. Codes for a living donor hepatectomy are divided based on which segments of the liver are removed (**47140-47142**). Codes for backbench preparation and reconstruction are divided based on the extent of work performed (**47143-47174**). Recipient codes are divided based on whether the transplant is orthotopic (*the transplanted organ is placed in the same position as the original organ*) or heterotopic (*the transplanted organ is placed in a position other than that of the original organ*) (**47135-47136**).

The donor and recipient require different diagnosis codes. A living donor is assigned a **Z** code indicating the donor status. Diagnosis codes for the organ recipient identify the condition(s) that describes why the transplant is necessary, as well as any comorbid conditions.

It is common for multiple physicians to be involved in various parts of the transplantation process, so each physician reports the appropriate code(s) for the services personally provided (■ FIGURE 35-10, page 654).

Modifier rules vary among the six types of organ transplants. Carefully review the MPFSDB to determine which transplant codes accept modifier **-66 Surgical team** and which codes require modifier **-51 multiple procedures**.

Repairs

Repair involves closing an opening—such as a laceration, fistula, or ostomy—or restructuring/reconstructing an anatomic site. This is in contrast to an incision made for drainage or to create an opening and in contrast to an excision, which removes tissue. Most Digestive System subheadings provide a category for Repair. To locate Repair codes in the Index, search for the one of the following:

- the Main Term **Repair** and a first-level modifying term for the anatomic site
- the name of the procedure, which usually ends with the suffix -plasty, -rraphy, or -pexy
- the name of the anatomic site and a first-level modifying term for **Repair**

In the Tabular List, review the details of the codes to select the one that describes the details of the procedure. Repair codes may appear as a parent code with several indented codes that describe variations of the procedure (■ FIGURE 35-11, page 654).

Adhesions

When performing procedures in the abdominal cavity, surgeons frequently encounter adhesions resulting from scarring from previous surgeries or inflammation. They must loosen, excise, or destroy the adhesions to reach the surgical site. CPT

A living donor match is found for a pediatric patient with congenital biliary atresia who has been on the liver transplant list. The transplant team consists of two surgeons. Surgeon A performs a hepatectomy of the left lateral segment on the living donor. Surgeon B performs the backbench reconstruction with two venous anastomoses and two arterial anastomoses. Both surgeons transplant the liver segment into the patient recipient. The transplant is orthotopic .

Surgeon A
Living donor:
Z52.6 Liver donor
47140 Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)

Surgeon B
Backbench reconstruction:
Q44.2 Atresia of bile ducts
47147 x 2 Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; arterial anastomosis, each
47146-51 x 2 Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation; venous anastomosis, each; -51 Multiple procedures

Surgeon A and Surgeon B
Transplant recipient:
Q44.2 Atresia of bile ducts
47135-66 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age; -66 Surgical team

Figure 35-10 ■ Example of Coding a Liver Transplant. *Source: © PB Resources, Inc. Used with permission. CPT codes only © American Medical Association.*

guidelines state that surgical destruction is part of a surgical procedure and, usually, should not be reported separately. This includes adhesions. When adhesions are so extensive that the surgeon spends a significant amount of time destroying or removing them to enable access to the surgical site, it might be possible to append modifier **-22 Increased procedural services** to the CPT code for the procedure. Documentation must identify the amount of excess time required, describe in detail what the surgeon did, and explain why the added time was necessary. In general, modifier **-22** should be used only when the added work has increased the operative time by 50% or more.

Separate codes for adhesiolysis are reported in the unusual circumstance when lysis is performed as a separate procedure. To locate adhesiolysis codes in the Index, search for the Main Term **Adhesions** and the first-level modifying term for the anatomic site.

Surgeon performs an esophagoplasty and closes a tracheoesophageal fistula using the thoracic approach.

43312 Esophagoplasty (plastic repair or reconstruction), thoracic approach; with repair of tracheoesophageal fistula

Figure 35-11 ■ Example of Coding a Repair on the Esophagus

Guided Example of Assigning Digestive System Procedure Codes

To practice skills for assigning codes for the Digestive System, continue with the guided example from earlier in the chapter about a patient who was seen for a colonoscopy. Follow along in your CPT manual as Jill Hynes, CPC, assigns codes. Check off each step after you complete it.

- ▶ First, Jill confirms the procedures: colonoscopy, polypectomy, hemorrhoidectomy.
- ▶ Jill searches the Index for the Main Term **Colonoscopy**.
  - ❑ She locates the first-level modifying term **Flexible**.
  - ❑ She locates the second-level modifying term **Removal**, then **Polyp**.
  - ❑ She identifies the codes to verify: **45384,45385**.
- ▶ Jill turns to the Tabular List to review and verify codes **45384-45385**.
  - ❑ She notices that **45384-45385** are indented codes, so she traces back through the Tabular List to locate the parent code, **45378**.
  - ❑ She reads the common part of code **45378** that appears before the semicolon: **Colonoscopy, flexible**. This code describes the basic colonoscopy provided, which extended from the anus to the cecum. She reads the second

part of the code description, **diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**, and confirms that it does not describe this procedure because a therapeutic procedure also was performed.

- ❑ She reads the indented description for code **45384, with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps** and confirms that this accurately describes the two polyps found in the sigmoid colon.
- ❑ She reads the indented description for code **45385, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** and confirms that this accurately describes the polyp found in the transverse colon.

▶ Jill checks for instructional notes in the Tabular List.

- ❑ She looks for instructional notes after the parent code, **45378**, and the indented codes she plan to use, **45384** and **45385**, and finds none.
- ❑ She refers to the beginning of the category **Endoscopy**, which appears before code **45300**, and reviews the special instructions that include definitions of endoscopic procedures on the colon.
- ❑ She understands that even though a polypectomy occurred in the sigmoid segment of the colon, she should not report a sigmoidoscopy; she should assign codes based on the farthest extent of the procedure, which was the entire length of the colon from the rectum to the cecum.
- ❑ She also reads the statement **Surgical endoscopy always includes diagnostic endoscopy**. This tells her that she should not use a separate code for the diagnostic portion of the procedure in addition to the codes for the polypectomies.
- ❑ She checks for special instructions at the beginning of the Digestive System subsection, before code **40490**, and finds none.
- ❑ She reviews the Surgery section guidelines that appear before code **10021** but does not find any information specific to endoscopies.

▶ Jill returns to the codes for the polypectomies: **45384** and **45385**.

- ❑ Because these codes share the same parent code (**45378**), she needs to determine whether they can both be reported.
- ❑ She confirms that there were no instructional notes directing her to not use the codes together.
- ❑ She recalls the multiple endoscopy rule that permits multiple codes from the same code family to be reported together. Both of these codes belong to the code family with the base code **43578**, so she knows that she can report both codes.

▶ Jill turns her attention to the hemorrhoidectomy.

▶ Jill searches the Index for the Main Term **Hemorrhoidectomy**.

- ❑ She locates the first-level modifying term **Ligation**.
- ❑ She identifies the code range to verify: **46221, 46945-46946**.

▶ Jill turns to the Tabular List to review and verify the codes.

- ❑ First she locates code **46221** and notices that codes **46945-46946** appear next because they are resequenced codes. She likes being able to review and compare all three codes together.
- ❑ She reads the description for code **46221**, **Hemorrhoidectomy, internal, by rubber band ligation(s)**. This sounds like the right description but she checks the other codes to be certain.
- ❑ She notices that code **46945** is a parent code for **46946**, and the common descriptor is **Hemorrhoidectomy, internal, by ligation other than rubber band**;
- ❑ She double checks the documentation and confirms the ligation method: Hemorrhoids were ligated with rubber bands. The documentation confirms that **46221** is the correct code because the code specifies **by rubber band ligation**.

▶ Jill reviews the Tabular List for instructional notes and finds two.

- ❑ The first instructional note appears after code **46221**: **(Do not report 46221 in conjunction with 45350, 45398)**. This note does not apply because she already determined that she is not reporting code **45350** or **45398**.
- ❑ The second instructional note appears after code **46946**: **(Do not report 46221, 46945, and 46946, in conjunction with 0249T.)** This note does not apply because she is not using code **0249T**.
- ❑ Jill also reviews the special instructions at the beginning of the subheading **Anus**, before code **46020**. The special instructions define the codes to use for various types of hemorrhoids and confirm that she selected the correct code for ligation of internal hemorrhoids.

▶ Jill reviews the procedure codes she has assigned for this case.

- ❑ **46221 Hemorrhoidectomy, internal, by rubber band ligation(s)**
- ❑ **45384 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**
- ❑ **45385 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

▶ Next, Jill must determine what modifiers are needed and how to sequence the codes.

CODING PRACTICE

Exercise 35.3 Assigning Codes for Digestive System Procedures

Instructions: Read the mini-medical-record of each patient's encounter. Review the information abstracted in Exercise 35.2 for questions 1–3. For questions 4–6, do the abstracting on your own. Assign CPT procedure codes using the Index and Tabular List. Write the code(s) on the line provided.

1. OUTPATIENT HOSPITAL Gender: M Age: 57

Preprocedure diagnosis: screening colonoscopy

Procedure: flexible colonoscopy, 2 polyps in descending segment, 1 polyp in transverse segment, remainder of colon to cecum was clear. Polyps were removed with bipolar cautery and submitted to pathology

Postprocedure diagnosis: adenomatous polyps per pathology report

Tip: Apply a modifier to identify this as a preventive service.

1 CPT Code _____

2. INPATIENT HOSPITAL Gender: F Age: 33

Diagnosis: morbid obesity, BMI = 43

Procedure: laparoscopic gastric bypass and Roux-en-Y gastroenterostomy (100 cm)

Tip: Identify the meaning of *gastroenterostomy* to determine the Roux-en-Y sites.

1 CPT Code _____

3. INPATIENT HOSPITAL Gender: F Age: 48

Diagnosis: squamous cell carcinoma of the esophagus

Procedure: near-total esophagectomy, thoracotomy, end-to-side pharyngogastrostomy (*restructure of the pathway from the throat to the stomach after esophagectomy*)

1 CPT Code _____

4. EMERGENCY DEPT Gender: M Age: 2

Reason for encounter: Mother brings in her son, who swallowed a toy piece

Procedure: rigid esophagoscopy through the mouth, retrieved plastic toy piece, no damage or laceration apparent

Diagnosis: esophagoscopy with foreign body removal

Tip: Abstract this procedure on your own before attempting to assign codes.

1 CPT Code _____

5. EMERGENCY DEPT Gender: F Age: 26

Diagnosis: abscess under the tongue

Procedure: superficial sublingual incision and drainage

Tip: Abstract this procedure on your own. Do not confuse the sublingual site within the mouth with the sublingual salivary gland.

1 CPT Code _____

6. LOCATION Gender: M Age: 36

Preprocedure diagnosis: rectal mass

Procedure: transsacral proctotomy to excise rectal tumor

Postprocedure diagnosis: stage I carcinoma of the rectum

Tip: Abstract this procedure on your own before attempting to assign codes.

1 CPT Code _____

ARRANGING CODES FOR DIGESTIVE SYSTEM PROCEDURES

When more than one procedure is performed during an operative session, coders must be attentive to modifiers and how to arrange (sequence) codes. The order of codes sometimes determines the modifiers needed. Some modifiers can be assigned at the same time the code is assigned, and some modifiers cannot be assigned until the codes are sequenced. Certain modifiers are required even when only one procedure is performed.

In general, multiple surgical procedures are sequenced in descending order of RVU, which corresponds to the complexity and price of the procedure. RVUs are provided in the MPFSDB and in most encoders and billing software programs.

Modifiers

Modifiers that have a special application for specific Digestive System codes have been discussed throughout this chapter and examples have been provided. This section summarizes those

modifiers and introduces some new ones. These are not the only modifiers that can be used with Digestive System codes. Refer to Appendix A of the CPT manual and to Chapters 29 and 31 of this text for more information about modifiers.

-33 Preventive Service

Modifier **-33** identifies certain procedures, such as a screening colonoscopy, as preventive care services under the Patient Protection and Affordable Care Act (PPACA). The United States Preventive Services Task Force (USPSTF) assigns one of five letter grades (A, B, C, D, or I) to recommend the likelihood of the net benefit of providing a preventive service. The PPACA requires that services rated as A or B be covered in full by private health plans. Copayments, coinsurances, and deductibles are not owed for these services under PPACA.

When a service on the approved list does not have a CPT code specifically described as preventive, assign modifier **-33** to indicate that the service was provided for preventive care. For example, CPT provides codes for preventive medicine E/M visits, so those codes do not need modifier **-33**. However, CPT does not provide a dedicated code for screening colonoscopies, so the code for a diagnostic colonoscopy (**45378**) must be reported. Append modifier **-33** to identify the colonoscopy as preventive in nature. The insurance company will waive the patient's copayment, coinsurance, and deductible and pay 100% of the allowed fee to the provider (■ Figure 35-12). A copayment may still apply if preventive care is not the *primary* purpose of the office visit or other services that require copayment are provided.

SUCCESS STEP

The USPSTF list of A and B services is updated annually and is available at **http://www.uspreventiveservicestaskforce.org/**. Other services eligible for modifier **-33** include certain routine immunizations recommended by the CDC and certain preventive care and screening services for children and women supported by the Health Resources and Services Administration (HRSA).

-51 Multiple Procedures

When multiple procedures are performed at the same operative session by the same provider, modifier **-51** indicates that payment should be reduced on the second and subsequent procedures because of the efficiencies gained. Procedures should be ordered in descending order by RVU, so that the most extensive procedure is paid in full and payment is reduced for the less extensive procedures. The standard Medicare rule for payment of multiple surgeries is to allow the full amount of the first procedure and allow the second through fifth procedures at 50% of the Medicare Physician Fee Schedule (MPFS) rate. Multiple procedures beyond six are priced **by report** (*based on a report submitted by the physician*). Private payers establish their own guidelines for payment of multiple procedures.

Do not append modifier **-51** to add-on codes or to codes with the symbol ⃠ (**modifier-51 exempt**). The MPFSDB and most encoders identify the codes for which this modifier is applicable.

-52 Reduced Services

The subcategory **Esophagogastroduodenoscopy** provides special instructions regarding modifier **-52** that appear before code **43235**. When the duodenum is not examined because it is not judged clinically relevant, append modifier **-52**. Likewise, if the duodenum cannot be examined for some other reason, such as retention of gastric contents, and a repeat examination is not planned, append modifier **-52**. Reduce the fee to be billed based on the extent of the service actually provided. Use of this modifier is required.

Special instructions at the beginning of the **Endoscopy** category for **Colon and Rectum** provide further direction on modifier **-52**. There are times when a therapeutic colonoscopy cannot proceed all the way to the cecum or small intestine, usually due to retained fecal matter. In this situation, append modifier **-52** to the therapeutic colonoscopy code. Submit appropriate documentation with the claim to explain the reason the procedure was reduced.

-53 Discontinued Procedure

The special instructions for the subcategory **Esophagogastroduodenoscopy** also include directions about modifier **-53**. In

Physician performs a routine screening colonoscopy on a patient, age 50.

45378-33 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure); -33 Preventive services

Modifier -33 Payment Calculation

Code	Modifier	Allowed fee	Patient co-insurance	Patient pays	Insurance pays
45378	33	$400.00	Waived	$0.00	$400.00
45378	None	$400.00	20%	$80.00	$320.00

Figure 35-12 ■ Example of Using Modifier -33. *Source: © PB Resources, Inc. Used with permission. CPT codes only © American Medical Association.*

the situation that the duodenum cannot be examined and a repeat examination *is planned*, append modifier **-53**.

CPT special instructions at the beginning of the **Endoscopy** category for **Colon and Rectum** provide additional guidance regarding this modifier. When a screening colonoscopy cannot proceed all the way to the cecum or small intestine, report the code for the full colonoscopy and append modifier **-53** to indicate that the procedure could not be completed. Use of this modifier is required. Reduce the fee to be billed based on the extent of the service actually provided. Submit appropriate documentation with the claim to explain the reason the procedure was discontinued.

-59 Distinct Procedural Service

Modifier **-59** is used to clarify that two procedures that might be considered to be bundled were performed on distinct sites or lesions or through distinct procedures. When the NCCI assigns the indicator 1 to a pair of surgical codes, modifier **-59** identifies that two separate services were provided. A common example of this with Digestive System procedures is when multiple therapeutic procedures from the same endoscopic code family are performed, as described under the multiple endoscopy rule discussed earlier in this chapter. Both indented codes are reported and modifier **-59** is appended to the second code of the pair.

In 2015, the Centers for Medicare and Medicaid (CMS) introduced four HCPCS modifiers to selectively identify subsets of procedures that would otherwise be reported with modifier **-59**. They are referred to as **X** modifiers and describe specific reasons that services should be considered as separate and distinct. When appropriate, use one of the following modifiers instead of modifier -59 for Medicare patients. Check with other payers to learn how they want these modifiers applied:

- **-XE Separate Encounter**—a service that is distinct because it occurred during a separate encounter
- **-XS Separate Structure**—a service that is distinct because it was performed on a separate organ/structure
- **-XP Separate Practitioner**—a service that is distinct because it was performed by a different practitioner
- **-XU Unusual Non-Overlapping Service**—the use of a service that is distinct because it does not overlap usual components of the main service

-66 Surgical Team

Surgical teams are used for liver and pancreas transplants. Each surgeon reports modifier **-66** on the code for the recipient transplantation. Payment is prorated among the surgeons based on the role of each documented in the operative report. Surgical teams are not paid for all components of a transplant. For example, harvesting a cadaver organ or backbench preparation may not qualify for a surgical team. Intestinal transplants do not qualify for a surgical team. In some cases, a cosurgeon (modifier **-62**) or assistant surgeon (modifier **-80**) is allowed. The MPFSDB identifies the modifiers accepted for each code. Many encoders and billing software programs also provide modifier information.

-PT Colorectal Cancer Screening Test, Converted to Diagnostic Test or Other Procedure

Assign this HCPCS Level II modifier for Medicare patients when a screening colonoscopy or other colorectal cancer screening test is converted to a diagnostic or therapeutic procedure. This includes any time that a treatment is performed during the screening, including removing a polyp, cauterization, dilation, and so on.

Guided Example of Arranging Digestive System Procedure Codes

To practice skills for assigning modifiers and arranging codes for procedures of the Digestive System, continue with the example from earlier in the chapter about the patient who was seen for a colonoscopy. Follow along in your CPT manual as Jill Hynes, CPC, arranges the codes. Check off each step after you complete it.

▶ First, Jill confirms the CPT codes.

- ❑ **46221 Hemorrhoidectomy, internal, by rubber band ligation(s)**
- ❑ **45384 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**
- ❑ **45385 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

▶ Jill reviews the RVUs for each code. She selects the facility RVUs because the physician is performing the procedure at an outpatient hospital facility rather than at a location he personally owns and operates. The RVU schedule defines *facility RVU* as a facility owned by a third party (other than the physician). Facility RVUs are used when the physician performing the service does not own the facility where the procedure is performed. Nonfacility RVUs are used when the physician performing the service owns the location where the procedure is performed. The facility RVUs and pricing do not reimburse the physician for facility-related costs, so they are lower than nonfacility RVUs and pricing, which reimburse the physician for facility-related costs, such as those for the building, equipment, and staff. (Note: Although this is not a Medicare patient, the MPFSDB is used because many private payers use Medicare RVUs and assign their own prices. In the workplace, follow the rules of each payer.)

- ❑ Code **45385** for the polypectomy using the snare technique is the most extensive service, with a facility RVU of 8.78. She sequences this code first.
- ❑ Code **45384** for the polypectomy using hot forceps is the second most extensive service, with a facility RVU of 7.74. She sequences this code second. Although two polyps were removed, the code description identifies the entire procedure. It does not provide direction to assign multiple occurrences of the code for each polyp removed, so she reports this code only once.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. D12.3 B. D12.5 C. K64.0 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	05	YY				22		45385		A	314 52	01		NPI	99 99999999
2	01	05	YY				22		45384	59	B	277 27	01		NPI	99 99999999
3	01	05	YY				22		46221	51	C	195 59	01		NPI	99 99999999

Figure 35-13 ■ CMS-1500 Form Billing for the Guided Example. *Source: © PB Resources, Inc. Used with permission. CPT codes only © American Medical Association.*

- ❑ Code **46221** for the hemorrhoid ligation is the least extensive service, with a facility RVU of 5.46. She sequences this code third.

▶ Jill reviews the codes to determine the need for modifiers. (Refer to Table 30-1 Key Criteria for Abstracting CPT Modifiers or Appendix A in the CPT manual.)

- ❑ Code **45385** does not require any modifiers because it is the primary procedure performed. She will link a diagnosis code for a polyp of the transverse colon to support this procedure.
- ❑ Code **45384** requires modifier **-59 Distinct procedural service** to clearly identify that the hot forceps polypectomy was a different lesion than the snare polypectomy. This will be clarified further when she links the diagnosis code for a polyp of the sigmoid colon. This procedure will be paid under the multiple endoscopy rule, not the multiple procedures rule, so modifier **-51 Multiple procedures** is not needed. (Some private payers might require modifier **-51** in addition to modifier **-59**.)
- ❑ Code **46221** requires modifier **-51 Multiple procedures** because the hemorrhoidectomy was performed during the same session as the colonoscopy. The payment will be reduced to 50% of the usual fee.

▶ Jill finalizes the procedure codes, modifiers, and sequencing for this case (■ FIGURE 35-13):

(1) **45384 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

(2) **45385-59 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique; -59 Distinct procedural service**

(3) **46221-51 Hemorrhoidectomy, internal, by rubber band ligation(s); -51 Multiple procedures**

▶ Jill also assigns and sequences the ICD-10-CM diagnosis codes that support the need for the service.

(1) **D12.3 Benign neoplasm of transverse colon**

(2) **D12.5 Benign neoplasm of sigmoid colon**

(3) **K64.0 First degree hemorrhoids**

CODING PRACTICE

Exercise 35.4 Arranging Codes for Digestive System Procedures

Instructions: Read the mini-medical-record of each patient's encounter, and review the information abstracted in Exercise 35.2 for questions 1-3. For questions 4-6, do the abstracting on your own. Assign CPT codes and modifiers using the Index and Tabular List, and arrange the codes in proper sequence. Write the code(s) on the line provided.

1. OUTPATIENT HOSPITAL Gender: M Age: 64

Diagnosis: initial incarcerated incisional hernia

Procedure: incarcerated incisional hernia repair with mesh

2 CPT Codes _____

2. OUTPATIENT HOSPITAL Gender: M Age: 61

Preoperative diagnosis: melena, hematemesis

Procedure: EGD was initiated with flexible scope through the mouth. Identified bleeding ulcers in esophagus and duodenum, which were successfully cauterized. Features of chronic gastritis were noted. No masses or hiatal hernia. Obtained biopsy from the antrum. Biopsies submitted to pathology for H&E

(*continued*)

CODING PRACTICE *(continued)*

2. (continued)

(*hematoxylin and eosin stain test to detect cancer*) and CLO (Campylobacter-*like organism test for* H. pylori).

Postoperative diagnosis: bleeding esophageal ulcer and bleeding peptic ulcer

Pathology report: biopsies negative for *H. pylori* and carcinoma

Tip: EGD with control of bleeding has a higher RVU than EGD with biopsy.

2 CPT Codes _____

3. INPATIENT HOSPITAL Gender: M Age: 3 months

Diagnosis: bilateral cleft lip with nasal deformity and cleft palate

Procedure: primary repair of a bilateral cleft lip and nasal deformity; repair of soft tissue of cleft palate and closure of alveolar ridge

Tip: Primary repair identifies a one-stage procedure.

2 CPT Codes _____

4. HOSPITAL Gender: F Age: 58

Preprocedure diagnosis: breast cancer with metastasis to the ileum and abdominal cavity

Procedure: Made a midline incision in the abdominal cavity. Excised tumors of 5 cm, 7 cm, 9 cm, and 12 cm in diameter from the peritoneum. Turned our attention to the ileum, from which a 75-cm segment was resected, and the healthy bowel was anastomosed in an end-to-end manner.

(*continued*)

4. (continued)

Tip: Abstract this procedure on your own. To locate the Main Term, use the medical term for cutting out part of the small intestine.

2 CPT Codes _____

5. INPATIENT HOSPITAL Gender: M Age: 57

Diagnosis: malignant ascites

Procedure: Under general anesthesia, created trocar ports in the abdomen and chest. Using the laparoscope, we inserted a tunneled intraperitoneal catheter, then inserted a subcutaneous extension from the catheter to exit from the chest.

Tip: Abstract this procedure on your own. A trocar is a sharp tool used to create openings and hold instruments used for laparoscopic surgery.

2 CPT Codes _____

6. INPATIENT HOSPITAL Gender: M Age: 74

Diagnosis: dysphagia following stroke

Procedure: Administered moderate sedation. Injected contrast medium. Under fluoroscopic guidance created gastrostomy, inserted feeding tube, and then converted to gastrojejunostomy tube.

Tip: Abstract this procedure on your own. The surgeon provided the image documentation and report.

2 CPT Codes _____

E/M CODING FOR GASTROENTEROLOGY

The *1997 Documentation Guidelines for Evaluation and Management Services* (1997 DG), published by CMS, do not provide guidelines for a single-system gastroenterology examination. Gastroenterologists use the multisystem examination criteria (■ FIGURE 35-14). To determine the appropriate E/M code, coders must review the documentation in detail and identify the specific elements documented.

- To translate the documentation into the E/M requirements for the history, refer back to Chapter 31, "Evaluation and Management Services (99201-99499)," Tables 31-7 to 31-10, or the 1997 DG.
- To determine the requirements for an examination, refer to Figure 35-14 or to the general multisystem examination in the 1997 DG.
- To determine the levels for medical decision making (MDM), refer to Chapter 31, Table 31-12, and to the Table of Risk in the 1997 DG.

Guided Example of E/M Coding for Gastroenterology

Refer to ■ Figure 35-15 Gastroenterology Encounter (page 663) to practice skills for abstracting and assigning E/M codes. Follow along as fictitious coder Jill Hynes, CPC, abstracts the procedure. Check off each step after you complete it.

▶ First, Jill needs to establish the category of service so she can determine the information needed to abstract and assign the code.

❑ *What is the setting?* Office.

System/Body Area	Elements of Multi-System Examination
Constitutional	❑ Measurement of any **three** of the following seven **vital** signs: • 1) sitting or standing blood pressure, • 2) supine blood pressure, • 3) pulse rate and regularity, • 4) respiration, • 5) temperature, • 6) height, • 7) weight (May be measured and recorded by ancillary staff) ❑ General **appearance** of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	❑ Inspection of **conjunctivae** and **lids** ❑ Examination of **pupils** and **irises** (eg, reaction to light and accommodation, size and symmetry) ❑ Ophthalmoscopic examination of **optic discs** (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages
Ears, Nose, Mouth and Throat	❑ External **inspection** of ears and nose (eg, overall appearance, scars, lesions, masses) ❑ Otoscopic examination of external **auditory canals** and **tympanic membranes** ❑ Assessment of **hearing** (eg, whispered voice, finger rub, tuning fork) ❑ Inspection of **nasal mucosa, septum** and **turbinates** ❑ Inspection of **lips, teeth** and **gums** ❑ Examination of **oropharynx:** oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	❑ Examination of **neck** (eg, masses, overall appearance, symmetry, tracheal position, crepitus) ❑ Examination of **thyroid** (eg, enlargement, tenderness, mass)
Respiratory	❑ Assessment of **respiratory effort** (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) ❑ **Percussion** of chest (eg, dullness, flatness, hyperresonance) ❑ **Palpation** of chest (eg, tactile fremitus) ❑ **Auscultation** of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ **Palpation of heart** (eg, location, size, thrills) ❑ **Auscultation** of heart with notation of abnormal sounds and murmurs Examination of: ❑ **carotid arteries** (eg, pulse amplitude, bruits) ❑ **abdominal aorta** (eg, size, bruits) ❑ **femoral arteries** (eg, pulse amplitude, bruits) ❑ **pedal pulses** (eg, pulse amplitude) ❑ **extremities** for edema and/or varicosities
Chest (Breasts)	❑ **Inspection** of breasts (eg, symmetry, nipple discharge) ❑ **Palpation** of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	❑ Examination of **abdomen** with notation of presence of masses or tenderness ❑ Examination of **liver** and **spleen** ❑ Examination for presence or absence of **hernia** ❑ Examination (when indicated) of **anus, perineum** and **rectum,** including sphincter tone, presence of hemorrhoids, rectal masses ❑ Obtain **stool sample** for occult blood test when indicated
Genitourinary	**MALE:** ❑ Examination of the **scrotal contents** (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) ❑ Examination of the **penis** ❑ Digital rectal examination of **prostate** gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including ❑ Examination of **external genitalia** (eg, general appearance, hair distribution, lesions) and **vagina** (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) ❑ Examination of **urethra** (eg, masses, tenderness, scarring) ❑ Examination of **bladder** (eg, fullness, masses, tenderness) Cervix (eg, general appearance, lesions, discharge) ❑ **Uterus** (eg, size, contour, position, mobility, tenderness, consistency, descent or support) ❑ **Adnexa**/parametria (eg, masses, tenderness, organomegaly, nodularity)

Figure 35-14 ■ 1997 DG for Multisystem Examination. *Source: Centers for Medicare and Medicaid Services, 1997* Documentation Guidelines for Evaluation and Management Services *(with formatting adjustments).*

Lymphatic	Palpation of lymph nodes in **two or more** areas: ❑ Neck ❑ Axillae ❑ Groin ❑ Other		
Musculoskeletal	❑ Examination of **gait and station** ❑ Inspection and/or palpation of **digits** and **nails** (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more** of the following six areas: ❑ 1) head and neck; ❑ 2) spine, ribs and pelvis; ❑ 3) right upper extremity; ❑ 4) left upper extremity; ❑ 5) right lower extremity; and ❑ 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any **misalignment,** asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of **range of motion** with notation of any pain, crepitation or contracture • Assessment of **stability** with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle **strength** and **tone** (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements		
Skin	❑ **Inspection** of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) ❑ **Palpation** of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)		
Neurologic	❑ Test **cranial nerves** with notation of any deficits ❑ Examination of **deep tendon reflexes** with notation of pathological reflexes (eg, Babinski) ❑ Examination of **sensation** (eg, by touch, pin, vibration, proprioception)		
Psychiatric	❑ Description of the patient's **judgment** and **insight** *Brief assessment of mental status including:* ❑ **Orientation** to time, place and person ❑ Recent and remote **memory** ❑ **Mood** and affect (eg, depression, anxiety, agitation, hypomania, lability)		
Total # Bullets Performed and Documented ➔	☐	**# of Elements Performed and Documented**	**Level of Examination**
		1–5	Problem focused
		6+	Expanded problem focused
		6 organ systems/body areas @ 2 bullet points each OR: 12 elements in at least 2 organ systems/body areas	Detailed
		ALL	Comprehensive (Perform all elements identified by a bullet in **at least nine** organ systems or body areas and document **at least two elements** identified by a bullet from **each of nine** areas/systems)

Figure 35-14 ■ (*continued*)

❑ *What is the type of service?* The encounter qualifies as a consultation because the gastroenterologist's advice is requested by the referring physician and the gastroenterologist sends a report back to the referring physician at the conclusion of the encounter.

❑ *What is the code range?* Jill refers to the CPT Index and looks up the Main Term **Evaluation and Management** and the subterm **Consultation**. The code range listed is **99241-99255**.

❑ *How many key components are required?* Jill refers to the code range in the Tabular List and notices that the Consultation subheading is divided into two categories: **Office or other outpatient** and **Inpatient**. She selects the **Office or other outpatient** category and reads the code description of the first code, which states **Office consultation for a new or established patient, which requires these 3 key components**. All codes in the category have the same requirements for key components. This tells her that all three key components must meet or exceed the levels listed in the code (3/3).

► Next, Jill identifies the level of history.

❑ *What is the level of HPI?* The HPI is **extended** because seven elements are documented.

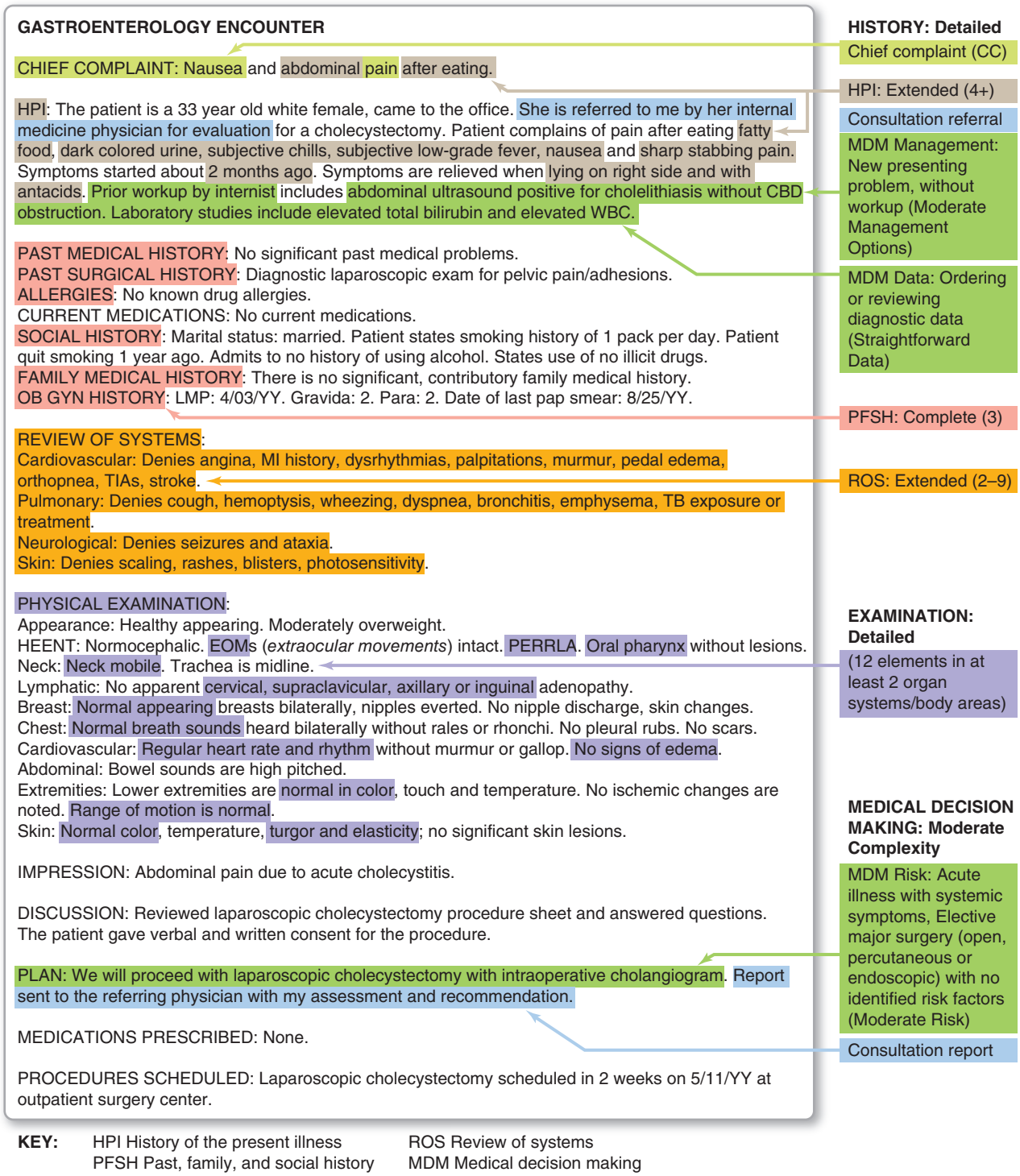

Figure 35-15 ■ Gastroenterology Encounter. *Source: © PB Resources, Inc. Used with permission.*

- ❑ *What is the level of ROS?* The ROS is **extended** because four systems are documented.
- ❑ *What is the level of PFSH?* The PFSH is **complete** because three elements are documented.
- ❑ *Based on these factors, what is the overall level of history?* The level of history is **detailed** because the lowest of the three factors (HPI, ROS, and PFSH) determines the history level. The HPI and PFSH qualify for a comprehensive history, but the ROS qualifies for only a detailed history.

▶ Jill refers to the multisystem examination in the 1997 DG (Figure 35-14) to abstract information needed to determine the level of the examination.

- ❑ *What is the level of examination?* The level of examination is **detailed**. Nineteen (19) elements in 4 organ systems

are documented, which exceeds the requirement of 12 or more elements in 2 organ systems for a detailed examination. A comprehensive examination requires documentation of at least two elements identified by a bullet from each of nine systems, which they are not.

- Jill determines the level of medical decision making. (Refer to Table 31-12 Medical Decision Making Levels.)

  - *What is the level of complexity of the number of diagnoses or management options based on the presenting problem?* The level is **moderate** because there is a new presenting problem without a workup by this provider. The workup was done by the referring provider.
  - *What is the amount and/or complexity of data to be reviewed?* The level is **Straightforward** because diagnostic data were reviewed.
  - *What is the level of risk of significant complications, morbidity, and/or mortality?* She reviews each column in the Table of Risk in the 1997 DG and determines that the level of risk is **Moderate** because the patient has an acute illness with systemic symptoms and elective major surgery is agreed to. The patient has no identified risk factors. The single highest element in the Table of Risk determines the overall risk. Both of these risk elements are classified as **Moderate**.
  - *Based on these factors, what is the overall level of medical decision making?* The medical decision making is **Moderate complexity**. At least two of the three MDM factors are required to qualify for a specific level of MDM. Two of the three MDM factors meet or exceed moderate decision making.

Now Jill is ready to assign the code for the GI encounter. The exercise that follows guides you through additional abstracting skills and allows you to assign the correct code.

CODING CAUTION

Verify that the physician signature is present in the medical record and is legible. If it is not, the physician must sign an attestation statement, which identifies the author. If the documentation for an encounter is not signed or attested to, Medicare considers the claim to be *insufficiently documented* and can deny or recoup payment.

CODING PRACTICE

Exercise 35.5 Evaluation and Management Coding for Gastroenterology

Instructions: Refer to the *1997 Documentation Guidelines for Evaluation and Management Services* (available at **www.cms.gov**) or Chapter 31, "Evaluation and Management Services (99201-99499)" (Tables 31-7 to 31-12), in this text. Answer the following questions about the Gastroenterology Encounter (Figure 35-15).

1. a. Which elements of the HPI are documented? Circle all that apply. Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated signs and symptoms
   b. How many elements are documented? _____
   c. What is the level of HPI? _____
2. a. Which systems are reviewed in the ROS? Circle all that apply. Constitutional, Allergic/immunologic, CV, Endocrine, ENT/M, Eyes, GI, GU, Hemic/lymphatic, MS, Neurologic, Psychiatric, Respiratory, Skin/breast
   b. How many systems are documented? _____
   c. What is the level of ROS? _____
3. a. Which PFSH elements are documented? Circle all that apply. Past medical, Family, Social
   b. What is the level of PFSH? _____
   c. What is the overall level of history? (The lowest history factor—HPI, ROS, or PFSH—determines the level of history.) _____
4. a. Refer to Figure 35-14 (1997 DG for Multisystem Examination). Which bulleted items are documented for the examination? (Check off the items documented.)
   b. How many bulleted items are documented? _____
   c. What is the level of the examination? _____
5. Refer to Table 31-12 Medical Decision Making Levels or the 1997 DG.
   a. What is the MDM level for the number of diagnoses or management options? _____
   b. What is the MDM level for the amount and/or complexity of data to be reviewed? _____
   c. Refer to the Table of Risk in the 1997 DG. Which elements of risk are documented for each risk factor?
      1. Presenting problem: _____
      2. Diagnostic procedures ordered: _____
      3. Management options selected: _____
   d. What is the level of risk? _____
   e. What is the overall level of MDM? (2 of the 3 MDM factors are needed to determine the overall level.) _____

6. a. What is the setting? _____
   b. What type of service? _____
   c. What is the code range? _____
   d. How many key components are required? _____
   e. What is the level of history? _____
   f. What is the level of examination? _____
   g. What is the level of medical decision making? _____
   h. What is the correct code? _____
   i. Is modifier -57 required? _____ Why or why not? _____
7. Abstract, assign, and arrange (sequence) the diagnosis codes that support the E/M code.

   1 ICD-10-CM Code _____

CHAPTER SUMMARY

In this chapter you learned that:

- Because the digestive, or alimentary, tract consists of and connects several anatomic sites, medical terms frequently contain word roots of multiple sites, which are combined with a procedural suffix.
- The CPT Surgery subsection Digestive System (**40490-49999**) contains 18 subheadings divided by anatomic site. Anatomic sites are arranged by the order in which they occur in the alimentary (digestive) tract, beginning with the lips and ending with the anus.
- Abstracting digestive system procedures requires special attention to the detailed anatomy of the digestive system and the order of the digestive organs within the GI tract, starting from either end.
- Coding for tonsillectomy, appendectomy, anastomosis, endoscopy, transplants, and repairs reinforces basic coding skills that you can use throughout the CPT manual.
- The order of codes sometimes determines the modifiers needed. Some modifiers can be assigned at the same time the code is assigned, and some cannot be assigned until the codes are sequenced. Certain modifiers are required even when only one procedure is performed.
- Gastroenterologists use the multisystem examination criteria because the *1997 Documentation Guidelines for Evaluation and Management Services* do not provide guidelines for a single-system gastroenterology examination.
- The Digestive System does not have any subsection guidelines or special instructions, but some subheadings and categories provide definitions and coding information. A special instruction that appears in each endoscopy or laparoscopy category directs that a surgical endoscopy or laparoscopy always includes a diagnostic one.

CONCEPT QUIZ

Take a moment to look back at the digestive system and solidify your skills. Try to answer the questions from memory first, then refer to the discussion in this chapter if you need a little extra help.

Completion

Instructions: Write the term that answers each question based on the information you learned in this chapter. Choose from the list below. Some choices may be used more than once and some choices may not be used at all.

anastomosis
antrectomy
colostomy
endoscopic sclerotherapy
ERCP
gastric bypass
herniorrhaphy
ileostomy
lap band
lithotripsy
Nissen fundoplication
paracentesis
Roux-en-Y
transthoracic esophagectomy
vagotomy

1. During a(n) _____, the upper part of the stomach is wrapped around the lower esophageal sphincter (LES).
2. A(n) _____ may be created to relieve a bowel blockage or obstruction in the large intestine.
3. _____ is a surgical puncture of a body cavity to remove excess fluid.
4. Gastrojejunostomy is another term used to describe a(n) _____.
5. A(n) _____ may be performed to repair bulging of internal organs or tissues through a defect in the wall of a body cavity.
6. The treatment of Barrett esophagus may include a(n) _____.
7. High-frequency sound waves, or_____, are used to break up gallstones.
8. A(n)_____ is the removal of the distal portion of the stomach due to gastric ulcers.

(*continued*)

(continued from page 665)

9. To reestablish gastrointestinal continuity after excision of portions of one or more organs, a(n) _____ may be performed.
10. When treating peptic ulcer disease, an open or laparoscopic _____ may be performed to relieve acid secretion.

Multiple Choice

Instructions: Circle the letter of the best answer to each question based on the information you learned in this chapter.

1. What HCPCS Level II code is used for a screening colonoscopy on a Medicare patient at high risk for colorectal cancer?
   A. G0104
   B. G0105
   C. G0107
   D. G0121
2. What procedure is an examination of the rectum, sigmoid colon, and part of the descending colon?
   A. Proctosigmoidoscopy
   B. Anoscopy
   C. Sigmoidoscopy
   D. Colonoscopy
3. What is the collective name for the salivary glands, liver, gall bladder, and pancreas?
   A. Accessory organs
   B. Omentum
   C. Hepatic system
   D. Digestive tract
4. What is the special instruction that appears in each endoscopy category?
   A. Surgical endoscopy always includes diagnostic endoscopy.
   B. Refer to CPT coding guidelines, Endoscopy.
   C. Surgical endoscopy codes should not be used with surgical laparoscopy codes.
   D. Surgical endoscopy includes radiologic guidance.
5. Which of the following codes is the base code for ERCP, diagnostic?
   A. 43260
   B. 43261
   C. 43274
   D. 43277
6. What abstracting question should be answered for an endoscopic procedure on the digestive system?
   A. Does the surgeon administer general anesthesia?
   B. How long does the procedure take?
   C. Is the procedure open or closed?
   D. What is the farthest site reached?
7. How are multiple surgical procedures sequenced?
   A. In numerical order
   B. In descending order of complexity and price
   C. In the order listed by the surgeon in the operative report
   D. According to the modifier(s) used
8. What modifier should be used when the duodenum is not examined during an EGD because it is not judged clinically relevant?
   A. -51
   B. -52
   C. -53
   D. -58
9. What does pull-through refer to?
   A. A surgical approach for an open procedure
   B. A type of laparoscopic procedure
   C. An anastomosis technique
   D. An ostomy technique
10. What modifier is used when a hemorrhoidectomy is performed during the same session as a colonoscopy?
    A. -51
    B. -52
    C. -58
    D. None

CODING CHALLENGE

Instructions: Read the mini-medical-record of each patient's encounter, then abstract, assign, and arrange ICD-10-CM diagnosis codes and CPT procedure codes using the appropriate Index and Tabular List. Write the code(s) on the line provided.

1. OUTPATIENT HOSPITAL Gender: F Age: 61

Diagnosis: recurrent inguinal hernia on the right side

Procedure: right inguinal herniorrhaphy

1 ICD-10-CM Code _____

1 CPT Code _____

2. OFFICE Gender: M Age: 52

Reason for encounter: lump and tenderness in jaw

Assessment: abscess, submandibular salivary gland; heavy current tobacco use

Procedure: incision and drainage of abscess

Tip: Read the instructional note under the code for the salivary gland abscess to identify the second code.

2 ICD-10-CM Codes _____

1 CPT Code _____

3. INPATIENT HOSPITAL Gender: M Age: 38

Diagnosis: fecal incontinence due to nontraumatic anal sphincter tear, which has not improved

Procedure: sphincteroplasty

Tip: Read the instructional notes under the code for nontraumatic anal sphincter tear to identify the second code.

2 ICD-10-CM Codes _____

1 CPT Code _____

4. INPATIENT HOSPITAL Gender: F Age: 52

Reason for encounter: RUQ pain, T 102 degrees, vomiting

Diagnosis: ultrasound revealed acute cholecystitis with CBD calculus causing obstruction

Procedure: laparoscopic cholecystectomy

1 ICD-10-CM Code _____

1 CPT Code _____

5. OUTPATIENT HOSPITAL Gender: M Age: 47

Reason for encounter: foreign body–like sensation in his proximal esophagus after a meal

Assessment: evaluated with lateral C-spine films and soft-tissue films without any evidence of perforation. The patient then was taken to the endoscopy suite.

Procedure: EGD with removal of a foreign body from gastroesophageal junction (piece of fish bone)

1 ICD-10-CM Code _____

1 CPT Code _____

6. OUTPATIENT HOSPITAL Gender: F Age: 57

Assessment: multiple severe external hemorrhoids

Procedure: removal of external hemorrhoids

1 ICD-10-CM Code _____

1 CPT Code _____

7. OUTPATIENT HOSPITAL Gender: M Age: 67

Reason for encounter: screening colonoscopy

Procedure: colonoscopy with snare removal of two adenomatous polyps, biopsy of suspicious lesion in transverse colon to rule out malignancy

Pathology report: benign polyps, benign lesion

Tip: Refer to the OGCR for sequencing guidelines for the diagnoses codes.

3 ICD-10-CM Codes _____

_____

2 CPT Codes _____

8. OUTPATIENT HOSPITAL Gender: M Age: 9

Diagnosis: chronic hypertrophic tonsillitis and adenoiditis, chronic otitis media refractory to antibiotics, left ear

Procedure: tonsillectomy and adenoidectomy, insertion of myringotomy tube under general anesthesia

2 ICD-10-CM Codes _____

2 CPT Codes _____

9. INPATIENT HOSPITAL Gender: F Age: 49

Diagnosis: ulcerative colitis involving primarily the rectosigmoid, unresponsive to steroids

Procedure: laparoscopic total abdominal colectomy with end ileostomy; splenorrhaphy to repair accidental puncture of spleen

2 ICD-10-CM Codes _____

2 CPT Codes _____

10. INPATIENT HOSPITAL Gender: M Age: 53

Assessment: admitted to the intensive care unit with complaints of abdominal pain and unstable vital signs

Procedure: repair of perforated duodenal ulcer, gastrojejunostomy and feeding jejunostomy placement

Postoperative diagnosis: perforated duodenal ulcer

1 ICD-10-CM Code _____

3 CPT Codes _____

_____

KEEP ON CODING

Instructions: Read the procedural statement, then use the appropriate Index and Tabular List to assign CPT procedure codes. Write the code(s) on the line provided.

1. Percutaneous endoscopic colostomy: CPT Code(s) _____
2. Transnasal biopsy of esophagus: CPT Code(s) _____
3. Esophagogastroduodenoscopy with cold forceps biopsy: CPT Code(s) _____
4. Hemiglossectomy: CPT Code(s) _____
5. Laparoscopic appendectomy converted to open due to extensive intestinal adhesions, which were lysed to provide access to the appendix. Enterolysis increased the time for the procedure by 50%: CPT Code(s) _____
6. Endoscopic retrograde cholangiopancreatography with stent placement: CPT Code(s) _____
7. Orthotopic liver transplantation by a surgical team with choledochostomy, standard bench prep of donor organ: CPT Code(s) _____
8. Open drainage of subphrenic abscess: CPT Code(s) _____
9. Left colon resection with colorectal anastomosis; complete mobilization of the splenic flexure: CPT Code(s) _____
10. Laparoscopic cholecystectomy with needle biopsy of liver: CPT Code(s) _____
11. Repair of nasolabial fistula: CPT Code(s) _____
12. Small-bowel resection for congenital atresia, approximately 1.5 feet; jejunostomy; placement of an abdominal wound VAC, wound surface area 20 sq cm: CPT Code(s) _____
13. Parotid gland needle biopsy: CPT Code(s) _____
14. Incarcerated ventral hernia repair: CPT Code(s) _____
15. Excision of full-thickness lip lesion with local flap reconstruction: CPT Code(s) _____
16. Flexible sigmoidoscopy with removal of foreign body: CPT Code(s) _____
17. Esophagogastroduodenoscopy with esophageal variceal band ligation: CPT Code(s) _____
18. Pelvic exenteration for colorectal malignancy with proctectomy and colostomy: CPT Code(s) _____
19. Revision of ileostomy: CPT Code(s) _____
20. Endoscopic ultrasound of sigmoid colon: CPT Code(s) _____
21. Gastric lavage: CPT Code(s) _____
22. EGD with dilation of gastric outlet for obstruction and biopsy of esophagus: CPT Code(s) _____
23. Closure of gastrostomy: CPT Code(s) _____
24. Suture of bleeding gastric ulcer: CPT Code(s) _____
25. Closure of anal fistula: CPT Code(s) _____