Chapter VI
Digestive
CPT-4 40000-49999

A. Introduction

The general policy statements defined previously also apply to procedures described by the CPT-4 range of codes, 40490-49999, that deal with the digestive system. The nature of services identified in this section requires specific clarification in relationship to these general policy statements.

B. Endoscopic Services

Endoscopic services are performed in many settings, i.e., office, outpatient, and ambulatory surgical centers (ASC). Procedures that are performed as an integral part of an endoscopic procedure are considered part of the endoscopic procedure. Services such as venous access (e.g., CPT-4 code 36000) and/or injection (e.g., CPT-4 codes 90780-90784), non-invasive oximetry (e.g., CPT-4 codes 94760 and 94761), anesthesia provided by the surgeon, etc. are included in the endoscopic procedure code. These components are not to be billed separately.

1. When a diagnostic endoscopy is performed in conjunction with endoscopic therapeutic services, the appropriate CPT-4 code to use is the most comprehensive endoscopy code describing the service performed. If the same therapeutic service is performed repeatedly (e.g., polyp removal) in the same area described by the CPT-4 narrative, only one CPT-4 code is billed with one unit of service. If different therapeutic services are performed and are not adequately described by a comprehensive CPT-4 code, the appropriate codes can be designated with the multiple procedure modifier ("51").

2. When a diagnostic endoscopy is followed by a surgical endoscopy and/or an open procedure, the diagnostic endoscopy is considered part of the surgical endoscopy/procedure (per CPT-4 definition) and is not to be separately billed.

3. Gastroenterologic tests included in CPT-4 codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal

and gastric washings for cytology are described as part of an upper endoscopy (CPT-4 code 43235) and, therefore, CPT-4 codes 91000 (esophageal intubation) and 91055 (gastric intubation) should not be separately billed when performed as part of an upper endoscopy procedure. Provocative testing (CPT-4 code 91052) can be expedited during gastrointestinal endoscopy (procurement of gastric specimens); when performed at the same time as GI endoscopy, CPT-4 code 91052 should be coded with the "52" modifier indicating reduced level of services were performed.

4. When a small intestinal endoscopy or enteroscopy is performed as a separate procedure, only the most comprehensive code describing the service performed is to be billed. When services described by the range of CPT-4 codes 44360-44386 (small intestine endoscopies) are performed as part of another service (e.g., surgical repair or creation of enterostomy, etc.), these codes are not separately billed (see separate procedure policy).

5. When endoscopic esophageal dilation is performed, the appropriate endoscopic esophageal dilation code is to be billed. The CPT-4 codes 43450-43458 (dilation of esophagus) are not used in addition (even if attempted unsuccessfully prior to endoscopic dilation).

6. When it is necessary to perform diagnostic endoscopy of the hepatic/biliary/pancreatic system using separate approaches (e.g., biliary T-tube endoscopy with ERCP, etc.) the appropriate CPT-4 codes for both may be billed. However, the code should include the "51" modifier indicating multiple procedures were performed at the same session.

7. When intubation of the GI tract is performed (e.g., percutaneous G-tube placement, etc.), it is not appropriate to bill a separate code for tube removal. Specifically, the CPT-4 code 43247 (removal of foreign body) is not to be billed for routine removal of therapeutic devices previously placed.

8. When an endoscopic or open procedure is performed and a biopsy is also performed, followed by excision, destruction or removal of the biopsied lesion, the biopsy is not separately billed. Additionally, when bleeding results from an endoscopic or surgical service, the control of bleeding at the time of the service is included in the endoscopic procedure. Separate procedure codes for

control of bleeding are not to be coded. In the case of endoscopy, if it is necessary to repeat the endoscopy at a later time during the same day to control bleeding, a procedure code for endoscopic control of bleeding may be billed with the "DS" modifier, indicating that this service represents a different session. In the case of open surgical services, the appropriate complication codes may be billed if a return to the operating room is necessary, but the complication code should not be billed if the complication described by the CPT-4 code occurred during the same operative session.

9. Only the most extensive endoscopic procedure should be is billed for a session. For example if a sigmoidoscopy is completed and the physician does a colonoscopy during the same session, only the colonoscopy, is coded. It is, however, acceptable to bill for multiple services provided during an endoscopic procedure (with the exception of treating bleeding induced by the procedure); these services would be reimbursed under the multiple endoscopic payment rules.

10. When a transabdominal colonoscopy (via colotomy) is performed at the same session as a standard sigmoidoscopy or colonoscopy, only the open colonoscopy (CPT-4 code 45355) is billed. A diagnostic endoscopy is always included in a surgical endoscopy per CPT-4 manual definition. Additionally, if a transabdominal colonoscopy is performed and followed by an open surgical procedure that is separately described in the CPT-4 manual (e.g., colectomy, etc.), only the open surgical procedure is billed (see sequential procedure policy).

C. Abdominal Procedures

When any open abdominal procedure is performed, an exploration of the surgical field is routinely performed to identify anatomic structures or any anomalies that may be present. Accordingly, an exploratory laparotomy (CPT-4 code 49000) is not separately billed with any open abdominal procedure. If routine exploration of the abdomen during an open abdominal procedure identifies abnormalities requiring a more extensive surgical field that makes the procedure unusual, the "22" modifier may be billed with supporting documentation in the medical record, indicating that an unusual procedural service was performed.

When, in the course of a hepatectomy, a cholecystectomy is necessary in order to successfully perform the hepatectomy, a separate procedure code is not coded for the cholecystectomy; component procedures necessary to perform a more comprehensive procedure are included in the code describing the more comprehensive service.

Appendectomies are commonly performed incidentally during many abdominal procedures. The appendectomy is only to be billed separately if it is medically necessary. If done incidental to another procedure, the appendectomy would be included in the major procedure performed.

When, in the course of an open abdominal procedure, a hernia repair is performed, a service is billed only if the hernia repair is medically necessary at a different incisional site. Incidental hernia repair in the course of an abdominal procedure that is not medically necessary should not be billed. The medical record should document the medical necessity of the service.

When a recurrent hernia requires repair, the appropriate recurrent hernia repair code is billed. A code for incisional hernia repair is not to be billed in addition to the recurrent hernia repair unless a medically necessary incisional hernia repair is performed at a different site. In this case the "DS" modifier should be attached to the incisional hernia repair code.

D. General Policy Statements

1. When a vagotomy is performed in conjunction with esophageal or gastric surgery, the appropriate CPT-4 code describing the comprehensive service is billed. The range of CPT-4 codes 64752-64760 includes services described by the vagotomy codes performed as separate procedures and are not billed in addition to esophageal or gastric surgical CPT-4 codes (e.g., 43635-43641) which include vagotomy as part of the service.

2. When a closure of an enterostomy or enteric fistula requires the resection and anastomosis of a segment of bowel, the CPT-4 codes 44625 and 44661, include the anastomosis or the enteric resection. Accordingly, additional enteric resection codes are not to be billed.

3. In accordance with the sequential procedure policy, only one code for hemorrhoidectomy is billed; the most extensive procedure necessary to successfully accomplish the hemorrhoidectomy would be appropriate. Additionally, if, in the course of a hemorrhoidectomy, an abscess is identified and drained, a separate procedure code is not billed for the incision and drainage, as this was performed in the course of the hemorrhoidectomy.

4. A number of groups of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be billed together (see mutually exclusive policy). While a number of these groups of codes exist in CPT-4, several specific examples include CPT-4 codes 45110-45121 for proctectomies, CPT-4 codes 44140-44160 for colectomies, CPT-4 codes 43620-43639 for gastrectomies, and CPT-4 codes 48140-48180 for pancreatectomies.

5. When it is necessary to create or revise an enterostomy, or remove or excise a section of bowel due to fistula formation, a separate enterostomy closure code or fistula closure code is not billed. In the case of creating or revising an enterostomy, the closure is mutually exclusive and in the case of fistula excision, the closure is included in the excision procedure.

6. Because the digestive tract is bordered by a mucocutaneous margin, several CPT-4 codes may define services involving biopsy, destruction, excision, removal, etc. of lesions of this margin. When a lesion involving this margin is identified and it is medically necessary to remove, only one code which most accurately describes the service performed should be submitted, generally either from the CPT-4 section describing integumentary services (10040-19499) or digestive services (40490-49999). For example, if a patient presents with a benign lip lesion, and it is removed with a wedge excision, it would be acceptable to bill the CPT-4 code 40510 (excision of lip) or the appropriate code from CPT-4 codes 11440-11446 (excision of lesions); billing a code from both sections would be inappropriate.

7. Laparoscopic procedures performed in place of an open procedure are subject to the standard surgical practice guidelines.