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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter VI
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A. Introduction

The general policy statements defined previously also apply to procedures described by the CPT 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. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a

minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. 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 code 36000) and/or infusion/injection (e.g., HCPCS/CPT codes 90760-90775, C8950-C8952), non-invasive oximetry (e.g., CPT codes 94760 and 94761), anesthesia provided by the surgeon, etc. are included in the endoscopic procedure code. These column two codes are not to be reported separately.

1. When a diagnostic endoscopy is performed in conjunction with endoscopic therapeutic services, the appropriate CPT code to use is the more comprehensive endoscopy code describing the service performed. If the same therapeutic endoscopy service is performed repeatedly (e.g., polyp removal) in the same area described by the CPT narrative, only one CPT code is reported with one unit of service. If different therapeutic services are performed and are not adequately described by a more comprehensive CPT code, the appropriate codes can be designated in accordance with the multiple GI endoscopy rules previously established by CMS.

2. When a diagnostic endoscopy is followed by a surgical endoscopy, the diagnostic endoscopy is considered part of the surgical endoscopy (per *CPT Manual* instruction) and is not to be separately reported.

3. Gastroenterologic tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of an upper endoscopy (CPT code 43235) and, therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) should not be separately reported when performed as part of an upper endoscopic procedure. Provocative testing (CPT code 91052) can be expedited during gastrointestinal endoscopy (procurement of gastric specimens); when performed at the same time as GI endoscopy, CPT code 91052 should be coded with modifier -52 indicating a reduced level of service was performed.

4. When a small intestinal endoscopy or enteroscopy is performed as a necessary part of a procedure, only the more comprehensive (column one) code describing the service performed is to be reported. When services described by the range of CPT codes 44360-44386 (small intestinal endoscopies) are performed as part of another service (e.g., surgical repair or creation of enterostomy, etc.), these codes are not separately reported. As noted previously, when an endoscopic procedure is confirmatory or is performed to establish anatomical landmarks ("scout" endoscopy), the endoscopic procedure is not separately reported. In the case where the endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform a more extensive (open) procedure is made, the endoscopic procedure may be separately reported. Modifier -58 may be used to indicate that the diagnostic endoscopy and the more extensive, open procedure are staged or planned services.

5. If esophageal dilation as described by CPT codes 43450-43458 is unsuccessful and followed by an endoscopic esophageal dilation procedure, only the endoscopic esophageal dilation procedure may be reported. The provider should not report the unsuccessful procedure.

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 codes for both may be reported. However, the code should include modifier -51 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 code 43247 (endoscopic removal of foreign body) is not to be reported 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 reported. 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 reported with modifier -78, indicating that this service represents a return to the endoscopy suite or operating room for a related procedure during the postoperative period. In the case of open surgical services, the appropriate complication codes may be reported if a return to the operating room is necessary, but the complication code should not be reported if the complication described by the CPT code occurred during the same operative session.

9. Only the more extensive endoscopic procedure is reported for a session. For example if a sigmoidoscopy is completed and the physician performs 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 for gastrointestinal endoscopy.

10. When a transabdominal colonoscopy (via colotomy)(CPT code 45355) and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g., colectomy), the endoscopic procedure(s) is (are) not separately reported. On the other hand, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the procedure(s) may be reported separately. Modifier -58 may be used to indicate that the diagnostic endoscopy and the open procedure are staged or planned services.

11. If the larynx is viewed through an esophagoscope during esophagoscopy, a laryngoscopy CPT code cannot be separately reported. However, if the laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy CPT codes may be reported with NCCI-associated modifiers.

D. 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 code 49000) is not separately reported 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, modifier -22 may be reported with supporting documentation in the medical record, indicating that an “unusual procedural service” was performed.

Hepatectomy procedures (e.g., CPT codes 47120-47130, 47133-47142) include removal of the gallbladder based on anatomic considerations and standards of practice. A cholecystectomy CPT code is not separately reportable with a hepatectomy CPT code.

Appendectomies are commonly performed incidentally during many abdominal procedures. The appendectomy is only to be reported separately if it is medically necessary. If done incidental to

another procedure, the appendectomy would be included in the major procedure performed.

If a hernia repair is performed at the site of an incision for an open abdominal procedure, the hernia repair is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.

When a recurrent hernia requires repair, the appropriate recurrent hernia repair code is reported. A code for incisional hernia repair is not to be reported in addition to the recurrent hernia repair unless a medically necessary incisional hernia repair is performed at a different site. In this case, modifier -59 should be attached to the incisional hernia repair code.

Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repairs is not separately reportable. CPT code 15831 (15830 in 2007) should not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable. In order to report an abdominoplasty in 2007, CPT requires the physician to report an infraumbilical abdominal panniculectomy (CPT code 15830 in 2007) plus the add-on CPT code 15847 for the abdominoplasty. Since NCCI bundles CPT code 15830 (in 2007) into abdominal wall hernia repair CPT codes, a provider should report CPT codes 15830 plus 15847 with modifier -59 appended to CPT code 15830 in order to report an abdominoplasty with an abdominal hernia repair CPT code.

CPT code 49568 is an add-on code describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. Although mesh or other prosthesis may be implanted with other types of hernia repairs, CPT code 49568 should not be reported with these other hernia repair codes. If a provider performs an incisional or ventral hernia repair with mesh/prosthesis implantation as well as another type of hernia repair at the same patient encounter, CPT code 49568 may be reported with modifier -59 to bypass edits bundling CPT

code 49568 into all hernia repair codes other than the incisional or ventral hernia repair codes.

Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44200) are defined by the *CPT Manual* as “separate procedures”. They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier -22 to the CPT code describing the latter procedure. The local carrier will determine whether additional payment is appropriate.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

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

4. When a closure of an enterostomy or enterovesical fistula requires the resection and anastomosis of a segment of bowel, the CPT codes 44626 and 44661, include the anastomosis or the enteric resection. Accordingly, additional enteric resection codes are not to be reported.

5. In accordance with the sequential procedure policy, only one code for hemorrhoidectomy is reported; the more 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 reported for the incision and drainage, as this was performed in the course of the hemorrhoidectomy. If the incision and drainage of the abscess occurred at a different site than the hemorrhoidectomy, then this procedure could appropriately be reported with modifier -59.

6. 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 reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, several specific examples include CPT codes 45110-45123 for proctectomies, CPT codes 44140-44160 for colectomies, CPT codes 43620-43639 for gastrectomies, and CPT codes 48140-48180 for pancreatectomies.

7. 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 reported. 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.

8. Because the digestive tract is bordered by a mucocutaneous margin, several CPT 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 more accurately describes the service performed should be submitted, generally either from the CPT 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 code 40510 (excision of lip) or the appropriate code from CPT codes 11440-11446 (excision of lesions); billing a code from both sections would be inappropriate.

9. Laparoscopic procedures performed in place of an open procedure are subject to the standard surgical practice guidelines. A surgical laparoscopy includes a diagnostic laparoscopy (CPT code 49320). If an unsuccessful laparoscopic procedure is converted to an open procedure, only the open procedure may be reported.

10. An open cholecystectomy includes an examination of the abdomen through the abdominal wall incision. If this examination is performed laparoscopically, it is not separately reportable as CPT code 49320 (diagnostic laparoscopy).

11. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers

should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

12. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

13. The NCCI edit with column one CPT code 45385 (Flexible colonoscopy with removal of tumor(s), polyp(s), or lesion(s) by snare technique) and column two CPT code 45380 (Flexible colonoscopy with single or multiple biopsies) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 45380 of this NCCI edit is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

14. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate

reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.