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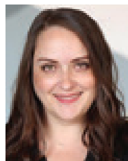
Coding Guidance for Common ASC Specialties

Understand the rules behind the codes

BY MANDEARA FRYE



Successful coding requires ASC coders to understand the rules concerning their ASCs' specialties and the procedures within those specialties. Individual specialties and procedures have their own unique coding rules.

Let us examine some of the quirkier and more confusing coding rules associated with common ASC specialties: gastroenterology, ophthalmology, orthopedics and pain management.

Gastroenterology

When coding esophageal dilations, read the operative report to determine the type of esophageal dilation performed. Some common CPT choices include the following:

- 43248—Esophagogastroduodenoscopy (EGD) with insertion of guidewire followed by passage of dilator through esophagus over guide wire
- 43249—EGD with balloon dilation less than 30 mm diameter
- 43233—EGD with balloon dilation 30 mm diameter or larger
- 43450—Dilation of esophagus by unguided sound or bougie (may or may not be done in the same setting as an EGD, which is separately reportable)
- 43453—Dilation of esophagus over guide wire

For endoscopic mucosal resections, understand the documentation requirements for accurate reporting. According to AMA *CPT Assistant* January 2017, to report 45390, documentation must support a submucosal injection to lift the lesion, demarcation of the lesion and endoscopic snare resection. If the demarcation is missing from the documentation, review other code options for the method of removal and the injection. For example, if documentation supports a snare removal as well as the injection, then report 45385 for the snare removal and 45381 for the injection pending documentation.

Finally, there remains confusion about what is considered a screening versus diagnostic colonoscopy. A few tips: If a symptom is documented, the procedure is no longer considered a screening. If the indication for the procedure is listed as "personal history of polyps," this may constitute a screening, according to *AHA Coding Clinic* (1st Quarter, 2017). If a patient scheduled for a screening is not due for one, according to US Preventive Services Task Force recommendations, review the history and physical (H&P) or query the surgeon to see if you should use another indication. Watch for symptoms to be documented in conjunction with screening, since the symptoms take precedence, and educate providers on coding rules.

Ophthalmology

If your ASC performs complex cataracts, learn your state's local coverage determination (LCD) criteria for these procedures, including specific diagnoses that may be required. While the American Medical Association (AMA) does not consider the use of trypan blue as complex, several Medicare administrative contractors do. The March 2016 *CPT Assistant* outlines criteria for complex cataracts. It specifies that installing and removing trypan blue from the anterior chamber does not justify a complex cataract (66982).

The additional work that does meet the requirement includes:

- A miotic pupil that does not dilate sufficiently and requires insertion of one of the following: four iris retractors through four additional incisions; a Beehler expansion device; a sector iridectomy with subsequent suture repair of an iris sphincter; or sphincterotomies created with scissors.
- A disease state that causes lens support structures to be weakened or absent and requires the lens implant to be supported with permanent intraocular sutures or a capsular tension ring to allow placement of an intraocular lens.

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- Pediatric cataract surgery.

Alternatively, some state LCDs say that a mature cataract requiring dye for visualization of capsulorrhexis does support CPT 66982.

Keep in mind, if trypan blue is overutilized as part of the physician's standard of care for the majority of cataract cases, then it may not be deemed medically necessary or warrant the complex code assignment.

When coding glaucoma shunts, pay attention to the approach, not just the type of shunt used. XEN Gel stents are typically associated with 0449T, with physicians using an ab interno approach to insert the stent through the cornea into the angle and then through the sclera where it emerges underneath the conjunctiva. The CPT code, however, describes the procedure, not the device. If a XEN Gel stent is inserted in the opposite direction, through the conjunctiva first, then through the sclera and then through the angle into the anterior chamber, this is considered an external approach. Code it with 66183.

Surgeons have begun using the Omni glaucoma treatment system to dilate Schlemm's canal. This is often documented as the dilation and a goniotomy. Even though there are no National Correct Coding Initiative (NCCI) edits between 66174 and 65820, AMA states to code only 66174 because the goniotomy is incidental and does not involve any additional physician work.

Orthopedics

According to the American Academy of Orthopedic Surgeons (*AAOS Bulletin*, April 2005), 29879 for knee arthroscopy with abrasion arthroplasty, drilling or microfracture can be reported per compartment. However, Medicare allows the reporting of 29879 only once per knee per session. Know your carrier guidelines so you do not miss potential revenue.

29875, for knee arthroscopy with limited synovectomy, has a separate procedure designation. This means it should never be reported with other knee arthroscopy codes. Even when performed in a separate compartment from a meniscectomy, do not code 29875 unless it is the only procedure performed.

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>
> *—Mandeara Frye Surgical Notes*

Concerning coding biceps tenotomy and tenodesis, know the difference between these terms. Tenotomy concerns the cutting of a tendon while tenodesis is suturing a tendon to bone. These common biceps procedures are performed arthroscopically. Biceps tenodesis is 29828, but there is no specific code for the biceps tenotomy. AMA directs coders to use a debridement code (29822/29823) for the biceps tenotomy, depending on the extent of the work. Something to keep in mind: If an extensive debridement is performed in another area of the shoulder, include the tenotomy.

Pain Management

When coding injections, pay attention to the approach. Is it a transforaminal or an epidural? Review the documentation to determine the entry point of the needle. Some techniques involve placing a needle into the epidural space, then advancing a catheter to exit the foramen. Although the foramen is involved, this is really an epidural (62321/62323) because of the approach into the epidural space. Transforaminal injections (64479-64484) require the needle to be advanced across the foramen.

For continuous infusion via catheter, the catheter must remain in place for more than a single day. According to the May 2017 *CPT Assistant*, "If the catheter is left in place to deliver substance(s) over a prolonged period (i.e., more than a single calendar day) either continuously or via intermittent bolus, use 62324, 62325, 62326, 62327, as appropriate."

If your surgeon fails to state that the catheter was removed, send a query. The documentation also should support securing the catheter for it to be considered indwelling.

For lumbar sympathetic blocks (64520), code per level, according to the December 2010 *CPT Assistant*. Review documentation to see if the injection is being performed at the L1, L2 and/or L3 levels and code each separately. *Note:* 64520 has a medically unlikely edit (MUE) of "1," so know your carrier guidelines.

Finally, know your payer's frequency limitations for injections to avoid denials. Medicare limits the number of injections per year. Now, many commercial carriers are adopting similar limits. Verify such limits to avoid denials.

Catching and Correcting Coding Mistakes

Considering the complex and confusing nature of coding, ASCs should undertake routine coding audits that review a meaningful number of codes submitted to payers and then compare those codes against what is supported in the documentation. It also is wise to seek out an external vendor to perform such audits. An external auditor—specifically one with ASC experience—can perform an objective examination that will help identify coding errors that can leave substantial amounts of money on the table. «

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