Endoscopic Procedures on the Esophagus

Type of Procedure
Upper Endoscopy Procedures (43234–43259)

Explanation of Procedure
The physician examines the upper gastrointestinal tract. The physician passes an endoscope through the patient’s mouth into the esophagus. The scope may be rigid or a flexible fiberoptic scope may be used. Depending on the type of upper endoscopy performed the documentation will indicate that the esophagus, stomach, duodenum, and sometimes jejunum are viewed.

Procedure Differentiation
These procedures are reported based on the anatomical structures visualized and any procedures that may be performed via the scope during the same operative session. Procedures include biopsy, excision of lesion, control of bleeding, dilation, etc. The code selection is first based on the structures visualized and then by the type of procedure performed. For example, a physician documents that the esophagus, stomach and duodenum are visualized and that a transmural fine needle biopsy of the esophagus was performed. In this instance, code 43242 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus) is appropriate. However, if the physician documents only visualization of the esophagus, an esophagoscopy code (in this example code 43232) is assigned and not a code indicating that the entire upper gastrointestinal tract was visualized.

The following table demonstrates codes that should be reported for esophagoscopies or esophagogastricduodenoscopy (EGD). An esophagoscopy includes an internal visual inspection of the esophagus through the use of an endoscope placed down the throat. An EGD is an internal visual inspection the esophagus, stomach, and duodenum.

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Key Documentation Terms
Within this area of procedures it is important to make sure that the documentation clearly identifies what was examined and the procedure(s) performed. Codes with in this section are further classified by the procedures performed (e.g., biopsy, injection, removal of foreign body, and removal of tumor).

When reporting procedures within this family of codes, each procedure must be clearly documented. For instance when performing code 43250 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery, at the minimum the documentation should include what was removed and the key terms “hot biopsy forceps” or “bipolar cautery.” Code 43251 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique, should include what was removed and the key terms “removal of” and “snare technique” in the documentation for the procedure.

Medical Necessity
The following conditions may warrant procedures in this family of codes:

- Barrett’s esophagus
- Chronic diarrhea
- Esophageal, gastric, or stomal ulcers
- Esophageal or proximal gastric varices
- Esophageal reflux
- Foreign body removal
- Gastrointestinal bleeding
• Gastric polyps
• Persistent vomiting
• Suspected neoplastic lesion

Coding Axiom

Coding Tips
• A diagnostic endoscopy includes the collection of specimens. A diagnostic esophagoscopy is designated as a separate procedure.
• Surgical endoscopy always includes a diagnostic endoscopy.
• It is acceptable to bill for multiple services provided during an endoscopic procedure (with the exception of treating bleeding induced by the procedure) when performed during the same operative session. For example, if an esophagoscopy with biopsy is performed, and the physician injects esophageal varices, then 43202 and 43204 may be reported. These services are reimbursed under the payer's multiple endoscopic payment rules.
• Diagnostic endoscopy procedures can be reported with open or incisional procedures.
• If the larynx is viewed through an esophagoscope during esophagoscopy, a laryngoscopy CPT code cannot be reported separately. However, if the laryngoscopy is performed with a separate laryngoscope, the laryngoscopy and esophagoscopy codes may be reported with Correct Coding Initiative (CCI) associated modifiers.
• Only the more extensive endoscopic procedure is reported for a session. For example, if an esophagoscopy is completed and the physician performs an esophagogastricduodenoscopy (EGD) during the same session, only the EGD is coded.
• Control of bleeding that is the result of a surgical procedure is not reported separately. 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.
• When biopsy of a lesion is performed followed by excision or destruction of the same lesion, the biopsy is not reported separately.
• When endoscopic esophageal dilation is performed, the appropriate endoscopic esophageal dilation code is reported. Codes 43450–43458 (dilation of esophagus) are not used in addition (even if attempted unsuccessfully prior to endoscopic dilation); in such a case, modifier 22 could be used to indicate an unusual endoscopic dilation procedure.
• Esophageal washings for cytology are described as part of an esophagoscopy and, therefore, should not be reported separately.
• If the same surgical endoscopy service is performed repeatedly (e.g., multiple polyps are removed through the scope), the service is reported only once.
• If two or more endoscopic procedures with the same endoscopic base code are reported on the same day, the procedures should be listed on the claim in descending order based on their RVUs. Modifier 51 should be attached to the lower-valued procedure(s).
• When performing a colonoscopy and multiple biopsies or polypectomies are performed, report the appropriate code once, even if multiple specimens or lesions are taken. Report both procedures and reimbursement will be calculated using the multiple endoscopy rules.

Coding Trap
Conscious sedation should not be reported in addition to many of the procedures in this section it is considered to be an integral part of the procedure. However, anesthesia services (00100–01999) may be billed separately when performed by a physician (or other qualified provider) other than the physician performing the procedure.

Billing and Payment Issues
Endoscopies are paid for under the Medicare fee schedule’s global surgery policy. A service that requires an incision for insertion of a scope has a post-operative period of 10 days. There is no postoperative period for endoscopies performed through such existing body openings as the anus or the mouth.

Regulatory Issues: Indications
These procedures can only be allowed if abnormal signs or symptoms or known disease are present. The following conditions are generally accepted as indication(s) for the performance of an EGD(s).

Indications Which Support EGD(s) for Diagnostic Purpose(s)
• Upper abdominal distress which persists despite an appropriate trial of therapy
• Upper abdominal distress associated with symptoms and/or signs suggesting serious organic disease (e.g., anorexia and weight loss)
• Dysphagia or odynophagia
• Esophageal reflux symptoms which are persistent or recurrent despite appropriate therapy
• Chronic diarrhea
• Persistent vomiting of unknown cause
• Other symptoms of disease in which the presence of upper GI pathology might modify other planned management. Examples include patients with a history of GI bleeding who are scheduled for organ transplantation, long-term anticoagulation, and chronic non-steroidal therapy for arthritis and those with cancer of the neck
• Radiologic findings of:
  – a suspected neoplastic lesion, for confirmation and specific histologic diagnosis
  – gastric or esophageal ulcer
  – evidence of upper gastrointestinal tract stricture or obstruction
• Gastrointestinal bleeding:
  – in most actively bleeding patients
  – when surgical therapy is contemplated
  – when re-bleeding occurs after acute self-limited blood loss
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- when portal hypertension or aorto-enteric fistula is suspected
- for presumed chronic blood loss and for iron deficiency anemia when colonoscopy is negative
- When sampling of duodenal or jejunal tissue or fluid is indicated
- To assess acute injury after caustic agent ingestion
- Intraoperative EGD when necessary to clarify location or pathology of a lesion. According to American Society for Gastrointestinal Endoscopy (ASGE) clinical guidelines, when upper gastrointestinal x-ray studies show a discrete duodenal crater as the only lesion, endoscopy is not usually indicated. (See "Sources of Information and Basis for Decision" section.)

Indications Which Support EGD(s) for Therapeutic Purpose(s)
- Treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (e.g., electrocoagulation, heater probe, laser photocoagulation or injection therapy)
- Sclerotherapy esophageal or proximal gastric and/or band of varices
- Other therapeutic injections
- Foreign body removal
- Removal of selected polypoid lesions
- Placement of feeding (peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
- Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilating systems employing guidewires)
- Palliative therapy of stenosing neoplasms (e.g., laser, bipolar electrocoagulation, stent placement)
- Management of achalasia (e.g., botulinum toxin, balloon dilatation)

Sequential or Periodic Diagnostic EGD
Sequential or Periodic Diagnostic EGD may be indicated for:
- Follow-up of selected esophageal, gastric or stomal ulcers to demonstrate healing (frequency of follow-up EGD is variable, but every two to four months until healing is demonstrated is reasonable)
- Follow-up in patients with prior adenomatous gastric polyps (approximate frequency of follow-up EGDs would be every one to five years depending on the clinical circumstance, with occasional patients with sessile polyps requiring surveillance more frequently)
- Follow-up for adequacy of prior sclerotherapy and/or band ligation of esophageal varices (approximate frequency of follow-up EGDs is very variable depending on the state of the patient, but every six to twenty-four months is reasonable after the initial sclerotherapy and/or band ligation sessions are completed)
- Follow-up of patients with Barrett’s esophagus without dysplasia the American Society for Gastrointestinal Endoscopy (2006) recommendation is: “For patients with established Barrett’s esophagus of any length and with no dysplasia, after 2 consecutive examinations within 1 year, an acceptable interval for additional surveillance is every 3 years.” If dysplasia is present, more frequent exams would be reasonable depending on the grade of dysplasia.
• Follow-up in patients with familial adenomatous polyposis
  (approximate frequency of follow-up EGDs would be every two to four
  years, but might be more frequent, such as every six to twelve months, if
  gastric adenomas or adenomas of the duodenum were demonstrated)