Question:
How do I report a diagnostic colonoscopy, if the prep is incomplete and the scope is able to be advanced past the splenic flexure, but does not get all the way to the cecum?

Answer:
Per CPT, if it is a diagnostic or screening colonoscopy, report, the diagnostic colonoscopy code (45378) with a 53 modifier.

*This response is based on the best information available as of 03/01/18.*

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Question:
In a diagnostic colonoscopy, if the prep is incomplete and the scope cannot be advanced past the splenic flexure, do I report a diagnostic colonoscopy (45378) with a modifier?

Answer:
No. CPT says if the scope cannot advance past the splenic
flexure, report a diagnostic sigmoidoscopy, code 45330.

*This response is based on the best information available as of 02/15/18.

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**Breast Cyst Aspiration**

February 1, 2018

**Question:**
The surgeon did a fine needle aspiration of two cysts in the same breast without any imaging. Is this billed once or twice?

**Answer:**
Fine needle aspiration of a breast cyst is reported per cyst. In this scenario, code 10021 with 2 units or 10021 and a second 10021 with a 59 or XS modifier as directed by your payor.

The fine needle aspiration codes are shown below.

**Fine Needle Aspiration (FNA)**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021</td>
<td>Fine needle aspiration; without imaging guidance</td>
</tr>
<tr>
<td>10022</td>
<td>with imaging guidance</td>
</tr>
</tbody>
</table>

Global Period for both codes – XXX

*XXX means the concept of global period does not apply

*This response is based on the best information available as of 02/01/18.
Laparoscopic Pyloroplasty Coding

January 18, 2018

**Question:**
How is a laparoscopic pyloroplasty reported?

**Answer:**
There is no current CPT code laparoscopic pyloroplasty, only an open code. An open code may not be used if a procedure is done laparoscopically. An unlisted code must be used. In this case, use code 43659, unlisted laparoscopic procedure, stomach.

*This response is based on the best information available as of 01/18/18.*

Billing an Appendectomy with Another Surgery

January 4, 2018

**Question:**
Is an appendectomy separately reported when done with another abdominal procedure?

**Answer:**
If the appendectomy is performed for a medically indicated purpose, for example the appendix was involved in the disease process, it can be reported with an add-on code, +44955. See the description of this code below. No modifier would be appended to this code and you should expect 100% reimbursement since add-on codes are valued lower since they are always reported with another procedure.

44955: Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)

*This response is based on the best information available as of 01/04/18.*

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**Defining Non-Compounded Sclerotherapy**

December 14, 2017

**Question:**
I’m not sure I understand the new vein surgery codes in the 2018 CPT manual. Can you explain what “non-compounded” means?

**Answer:**
The new 2018 coded, 36465, 36466 describe injection(s) of a non-compounded foam sclerosant into an extremity truncal vein...
(eg, great saphenous vein, accessory saphenous using ultrasound-guided compression of the junction of the central vein (saphenofemoral junction or saphenopopliteal junction). The sclerosant comes ready to use, it does not need to be compounded (prepared or mixed) by the provider. Note that these new codes also include ultrasound-guided compression. Code 76942 for ultrasound guidance would not be separately reported.

The existing sclerotherapy codes, for example, 36470, sclerotherapy injection of sclerosant, single incompetent vein (other than telangiectasia), describe a sclerosant solution that is mixed (compounded) by the provider prior to injection.

The codes for non-compounded (36465-36466) and compounded (36470-36471) sclerotherapy are shown below.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Global Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>36465</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein) <strong>New in 2018</strong></td>
<td>10</td>
</tr>
<tr>
<td>36466</td>
<td>multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg <strong>New in 2018</strong></td>
<td>10</td>
</tr>
<tr>
<td>36470</td>
<td>Injection of sclerosing solution; single vein</td>
<td>10</td>
</tr>
<tr>
<td>36471</td>
<td>multiple veins, same leg</td>
<td>10</td>
</tr>
</tbody>
</table>

*Global Days – 10*
Question:
Can add-on code 49905 (omental flap) be reported for buttressing an incision or anastomosis? For example after a colectomy? Or is the intent of the code, reconstruction of a defect only.

49905 Omental flap, intra-abdominal (List separately in addition to code for primary procedure)

Answer:
No, buttressing a formed anastomosis (made by staples or sutures) with extra suture, mesenteric fat, or even fibrin sealant is all considered inherent to the creation of that anastomosis and would not be separately reported.
Thrombectomy in the Dialysis Circuit

November 2, 2017

Question:
If thrombectomy is performed once in the peripheral segment and once in the central segment of the dialysis circuit, can code 36904 be reported twice?

Answer:
Code 36904 is reported once, no matter how many times thrombectomy is performed in the peripheral and/or central segment.

*This response is based on the best information available as of 11/02/17.

Documenting time for moderate sedation in endoscopy: Is it Scope in to Scope out?
What’s causing the revenue loss in endoscopy center?