Surgery: Digestive System

Page updated: September 2020

This section contains information to assist providers in billing for surgical procedures related to the digestive system.

Frenotomy

Incision of lingual frenum (frenotomy), CPT® code 41010, does not require a *Treatment Authorization Request* (TAR). This service:

- Is reimbursable only for recipients younger than 1 year of age
- Is a once-in-a-lifetime procedure
- Is reimbursable for primary surgeon services only (assistant surgeon services are not payable)
- Is reimbursable to Non-Physician Medical Practitioners (NMPs)

Frenoplasty

When billing for CPT code 41520 (frenoplasty [surgical revision of frenum, for example, with Z-plasty]), providers must attach an operative report to the claim that clearly indicates frenoplasty.

Note: A simple incision or excision of the frenum without revision is not frenoplasty.

Morbid Obesity: Surgical Treatment

Surgical treatment of clinically severe obesity (Body Mass Index [BMI] of greater than or equal to 40) should not be billed with CPT code 43999 (unlisted procedure, stomach), but should be billed with specific CPT codes. Morbid obesity can be a health danger because of the associated increased prevalence of cardiovascular risk factors such as hypertension, hypertriglyceridemia, hyperinsulinemia, diabetes mellitus and low levels of high-density lipoprotein (HDL) cholesterol. Conservative and dietary treatments include low (800 thru 1200) calorie and very low (400 thru 800) calorie diets, behavioral modification, exercise and pharmacologic agents. When these less drastic measures have failed or are not appropriate, providers may use the following surgical treatment options for morbidly obese recipients. TAR approval is required.

‹‹Billing for Surgical Procedures››

CPT Code	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (150-100cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Removal and replacement of subcutaneous port component only

TAR Requirements

Approval of a *Treatment Authorization Request* (TAR) for CPT codes 43644, 43645, 43770 thru 43775, 43842, 43843, 43845 thru 43848 and 43886 thru 43888 is required and must include all of the following documentation:

- The recipient has a BMI, the ratio of weight (in kilograms) to the square of height (in meters), of:
  - Greater than 40, or
  - Greater than 35 if substantial co-morbidity exists, such as life-threatening cardiovascular or pulmonary disease, sleep apnea, uncontrolled diabetes mellitus, or severe neurological or musculoskeletal problems likely to be alleviated by the surgery.
- The recipient has failed to sustain weight loss on conservative regimens. Examples of appropriate documentation of failure of conservative regimens include but are not limited to:
  - Severe obesity has persisted for at least five years despite a structured physician-supervised weight-loss program with or without an exercise program for a minimum of six months.
  - Serial-charted documentation that a two-year managed weight-loss program including dietary control has been ineffective in achieving a medically significant weight loss.
- The recipient has a clear and realistic understanding of available alternatives and how his or her life will be changed after surgery, including the possibility of morbidity and even mortality, and a credible commitment to make the life changes necessary to maintain the body size and health achieved.
- The recipient has received a pre-operative medical consultation and is an acceptable surgical candidate.

- The recipient has an absence of contraindications to the surgery, including a major life-threatening disease not susceptible to alleviation by the surgery, alcohol or substance abuse problem in the last six months, severe psychiatric impairment and a demonstrated lack of compliance and motivation.
- The recipient has a treatment plan, which includes:
  - Pre-and post-operative dietary evaluations and nutritional counseling, counseling regarding exercise, psychological issues, and the availability of supportive resources when needed.
- Repeat bariatric surgery or surgical revision may be medically necessary to correct complications or technical failure including implanted device failure, gastric pouch of inappropriate size or stricture, fistula, obstruction or other surgical complication.
- Request for repeat surgery for failure to achieve or sustain weight loss must include documentation that the patient has been enrolled in and compliant with the previous post-operative program.

Esophagus and Esophagogastroduodenoscopy with Optical Endomicroscopy

CPT codes 43206 (esophagoscopy, flexible, transoral; with optical endomicroscopy) and 43252 (esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy) must be billed "By Report."

Endoscopy

CPT code 43211 (esophagoscopy, flexible, transoral; with endoscopic mucosal resection) is not reimbursable with CPT code 43202 when biopsy is performed on the same lesion. Providers must document when the procedure is performed on a different lesion in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Percutaneous Biliary Procedures

When billing for the following codes, providers should document on the claim form that a different access was used.

‹‹Billing for Surgical Procedures››

CPT Code	Description
47531	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance [eg, ultrasound and/or fluoroscopy] and all associated radiological supervision and interpretation; existing access
47532	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance [eg, ultrasound and/or fluoroscopy] and all associated radiological supervision and interpretation; new access
47533	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance, and all associated radiological supervision and interpretation; external
47534	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance, and all associated radiological supervision and interpretation; internal
47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance, and all associated radiological supervision and interpretation
47536	Exchange of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance, and all associated radiological supervision

‹‹Billing for Surgical Procedures (continued)››

CPT Code	Description
47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance, including diagnostic cholangiography when performed, imaging guidance, and all associated radiological supervision and interpretation
47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance, balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, each stent; existing access
47539	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance, balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, each stent; new access, without placement of separate biliary drainage catheter
47540	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance, balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, each stent; new access, with placement of separate biliary drainage catheter

Endoscopic Retrograde Cholangiopancreatography (ERCP)

CPT code 43262 (endoscopic retrograde cholangiopancreatography for [ERCP]; with biopsy, single or multiple) is not reimbursable with CPT code 43274 for stent placement or replacement in the same location. Providers must document procedure performed on a different location in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

CPT 43276 (endoscopic retrograde cholangiopancreatography [ERCP]; with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged) is not reimbursable with CPT code 43274 for stent placement or replacement of same stent. Providers must document use of different or additional stent in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Modifier 59

CPT codes 43274 (with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent), 43276 and 43277 (Endoscopic retrograde cholangiopancreatography; with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla [spinchteroplasty], including sphincterotomy, when performed, each duct) may be billed with modifier 59 for each additional stent.

Providers should bill for CPT code 47542 (balloon dilation of biliary duct(s) or of ampulla, percutaneous, including imaging guidance, and all associated radiological supervision and interpretation, each duct) with modifier 59 with additional dilation only once, regardless of the number of additional ducts dilated.

‹‹Endoscopic Ultrasound-Guided Measurement

HCPCS code C9768 (endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method) is reimbursable for the primary surgeon only. Assistant surgeon services are not reimbursable. List this code separately in addition to the code for the primary procedure.››

Anoscopy with Submucosal Injection

Providers may use CPT code 46999 (unlisted procedure, anus) when billing for anoscopy with submucosal injection. This code requires a TAR and is reimbursable for primary surgeon services only. Billing is “By Report.”

Preparation of Fecal Microbiota for Instillation

CPT code 44705 (preparation of fecal microbiota for instillation, including assessment of donor specimen) must be billed "By Report."

Colonoscopy Through Stoma

CPT code 44405 (colonoscopy through stoma; with transendoscopic balloon dilation) must be billed with modifier 59 for each stricture dilated.

Colon and Rectum: Unlisted Procedure

CPT code 45399 (unlisted procedure, colon) is reimbursable for primary surgeon services with a Treatment Authorization Request (TAR). Assistant surgeon services do not require a TAR.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.