

Hemorrhoidal Band Ligation Procedures Performed in the ASC in Conjunction with Proctosigmoidoscopy, Sigmoidoscopy or Colonoscopy

2010 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing a hemorrhoidal band ligation in conjunction with a proctosigmoidoscopy, sigmoidoscopy and/or a colonoscopy utilizing the Cook® ShortShot® Saeed Hemorrhoidal Multi-Band Ligator with TriView® banding set, in a free-standing colonoscopy center subject to Medicare's Ambulatory Surgery Center (ASC) payment system.

Coverage

Most health plans contain language stating they will only pay for services deemed medically necessary. This could possibly include only paying for ligation of symptomatic hemorrhoids. Physicians and ambulatory surgery centers should be aware of the usual requirements for medical necessity and check their local health plans' coverage policies before performing procedures and/or submitting claims for services.

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>), and are encouraged to contact their local carrier medical director (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

CPT procedural codes exist to report proctosigmoidoscopy, sigmoidoscopy, colonoscopy, hemorrhoidal band ligation and anoscopy procedures by physicians in all outpatient and inpatient facility settings.

45300-45327	Proctosigmoidoscopy (code family)
45330-45345	Sigmoidoscopy (code family)
45378-45392	Colonoscopy (code family)
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)
46600	Anoscopy, diagnostic, with or without collection of specimens

National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (CMS) "developed the National Correct Coding Initiative to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B Claims."¹ Most payers today apply the NCCI edits to the adjudication of medical claims to avoid costly procedure unbundling (unbundling - when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code). Correct coding convention dictates "procedures should be reported with the HCPCS/CPT codes that most comprehensively describe the services performed."²

Codes assigned edits may or may not be paid separately in accordance with correct coding convention of the Medicare Physician's Fee Schedule. Currently, diagnostic anoscopy performed in conjunction with lower gastrointestinal endoscopy procedures is a bundled procedure and would not be separately reported or paid.

1. National Correct Coding Initiative Policy Manual for Medicare Services Version 14.3, pg viii
2. National Correct Coding Initiative Policy Manual for Medicare Services Version 14.3, pg xi

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.

Global Surgery Indicators

Minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period are included in the fee schedule amount. Evaluation and management services on the day of the procedure and during the 10 day postoperative period are generally not payable.¹

CPT Code	Global Days
45300-45327	0 days
45330-45345	0 days
45378-45392	0 days
46221	10 days
46600	0 days

1. Medicare Physician Fee Schedule Database (MPFSDB) Key

Payment

Physician

Most payers have adopted Medicare's multiple procedure discount payment rules for multiple procedures performed at the same operative setting. Under these rules, the highest valued service is paid at its full fee schedule amount (less patient deductibles and coinsurance) while payment for additional procedures is reduced by 50%. If hemorrhoidal banding (CPT code 46221) is performed with a diagnostic colonoscopy (CPT code 45378), for example, the colonoscopy will be paid in full and the banding will be reduced by 50%. There will not be any payment for the anoscopy (CPT code 46600) if the payer applies NCCI edits.

Ambulatory Surgery Centers (ASCs)

ASC facilities use the same CPT codes as physicians to report services. Medicare has an approved list of services that can be provided in an ASC setting and the ASC receives a facility payment. Physicians are paid separately at the reduced Facility payment rate of the Physician Fee Schedule.

2010 Medicare reimbursement for hemorrhoidal band ligation performed in conjunction with a diagnostic colonoscopy (this code was chosen for illustrative purposes) is detailed below in Table 2.

Table 2: 2010 Medicare ASC and Physician Reimbursement

Code	Descriptor	ASC Fee Schedule (National Medicare Average)	Physician Fee Schedule (National Medicare Average)
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic	\$379.80	\$219.03 ²
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	\$68.22 ¹	\$87.39 ^{1,2}
46600	Anoscopy; diagnostic	\$0 ³	\$0 ³

1. Reduced by 50% because of multiple procedure discount

2. Paid at Facility rate

3. No payment due to NCCI edits

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2010 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/PFSlookup/02_PFSsearch.asp#TopOfPage

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage>



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