Message	Response Message
How would you code for revision of ileostomy with repair of paraileostomy hernia? There is a CPT for comparable scenario for colostomy w/paracolostomy hernia, but not for ileostomy.	44314 is the separate procedure code for revision of ileostomy. If the revision is done in conjunction with a hernia repair, I would use 44314 along with a code for the hernia repair.
I thought that a hernia at the site of another open procedure was bundled?	Does the documentation show that the revision is complicated or simple? While true that if the same incision is used for both procedures it may be bundled...how complicated was the revision?
For lap colectomy, who would I code for a lap biopsy. Do I have to use the unlisted code?	Is the biopsy the reason for the colostomy?
No. Sometimes they find a liver lesion and need to biopsy while they are performing the colectomy.	In this case, a separate biopsy procedure is totally appropriate. According to the guidelines, if the biopsied lesion is not in the same area as the intestinal procedure, the biopsy can be coded as a separate code.
For a polypectomy done via biopsy forceps, would hot or cold forceps have to be documented or would you assume one over the other?	Always go by documentation; you would never want to assume.
How would you code for transcanal hemorrhoidal dematerialization along with hemorrhoidopexy along with ultrasound guidance?	46946, a new code and out of sequential order and 76998 for Ultrasonic guidance, intraoperative. This may change with the new codes this year.
How would you code a takedown colovaginal fistula (not rectovaginal) (i.e. ascending colon stuck down to vagina-post hysterorectomy/no uterus) with or with out resection?	The codes available now include rectovaginal, urethralvaginal and vesicovaginal. An unlisted code with a copy of the report would be more accurate.
What's the best ICD 9 for personal history colitis or personal history diverticulosis? V12.79?	As much as I detest XXX.X9 codes, there really isn't one more accurate. However, if your population is experiencing these history codes, with enough input, we can get a more accurate code, and ICD-10 allows for a lot more accuracy that way.
Would a flex sig through colostomy to check stoma viablility performed post Hartmann procedure be considered inclusive in the 90 day global period?	If it is viabilty of the initial procedure, yes, unless a complication is discovered while the viability check is happening.
Our surgeon is now performing the Fistulectomy LIFT (ligation of intersphincteric fistula tract) procedure. There is some argument over whether he can use the 46275 fistulectomy intersphincteric code versus an unlisted anus. What are your thoughts?	I beleive in the revised version of this code, acccording to the CPT insider, this code is perfect for what you are describing. It is still treating and anal fistula but the appraoch is slightly different?

When an endoscopy is performed and the provider removes food, can this be billed as removal of foreign body?	Technically there is some assumption that there will be food or other digested material within the digestive tract, within the pure definition, this really isn't a foreign body.
RE: Transanal excision of rectal tumors. Is above/below the dentate line a good indicator whether to code a transanal excision rectal tumor versus surgical excision of anal polyp?	The descriptors for these codes really do not make a concrete method of what is what. I believe using the dentate line, provided there is a mention of exactly where the polyp was removed, is a great way to keep your internal audits correct and your coding consistant.
Are VAC placements ever billable with colectomies?	It is my understanding that the placement isn't billable but the DME involved is billable for periodic 30 day checks to see that it is still needed, etc.
If a screening colonoscopy is boarded (patient reported no symptoms at the time it was scheduled) and then the patient informs the nurse during the history/physical before the procedure that they've had some bleeding and change in bowel, would the V76.51 still be listed as the primary ICD9 since that was the original intent of the procedure?	You would still report V76.51 with a secondary diagnosis of symptoms or findings documented by the provider.
RE: LIFT, they perform a ligation of the tract versus an excision to my understanding but still treating the fistula tract at the intersphincteric level.	That's what I believe, and simple ligation is always included in the procedure.
Weren't there 3 lesions and 3 techniques used in the example on slide 34?	Code 45385 includes the use of the snare technique. 45385: Colonscopy with removal of tumor(s), polyp(s), and or other lesion(s) by snare technique.
There is no CPT code for splenic flexure mobilization in conjunction with total colectomy. Would you still code it separately using an unlisted code or is that included in the total colectomy CPT code?	These are the only codes to which 44139 may be added. When describing add-on codes, the CPT manual typically lists all the codes to which an add-on code may be added (unless the add-on code can be added to many codes). Furthermore, 44139 clearly mentions a partial (as opposed to total) colectomy. As a result, billing 44139 with 44150 (colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy) is incorrect. This also makes sense clinically. Because a total colectomy involves removing all of the colon, the splenic flexure would be mobilized in any case, and the work involved in doing so is likely already incorporated into the value of the procedure.

If the food is impacted and causing obstruction?	If the food is causing the impaction, the diagnosis would be fecal impaction and again...this is "normal" to find in the digestive system. If however, this impaction is causing an abcess, then we have a different matter.
So what would be coded if the pt has a virtual colonoscopy and find polyps that need removal?	You would see the polyps on the virtual, however, the procedure to remove tham would be a separate procedure, because by definition, the virtual is just that, virtual, no procedure being done.
What CPT code would you use for endoscopy resection?	I cannot find an endoscopic resection. 44799 with a report.
How much of the terminal ileum needs to be removed to report code 44160?	Rule of thumb, 10 to 20 cm. I got this from a physician I once worked for. It was documented this way and the code reported this way.
Is the staging prcess the same for all malignancies?	Yes, the staging procedure is the same. This link will explain it more. http://medical-dictionary.thefreedictionary.com/TNM+classification+for+staging+malignancy
During an ERCP the physician perfomed a biopsy in the duod on the way out. what biopsy code would be more appropriate 43239 or 43261?	43261 is more appropriate because the ERCP was the major procedure.
What code are you using for STEP Procedure?	At the present time I am using an unlisted code and sending a report…44799. unlisted procedure, intestine. I have every hope that the new CPTs may have more guidance for this, and the ICD-9 had many more codes for digestive problems this year.
One of the samples seemed to be incorrect. Why use 44150 for total colectomy with ileosigmoidostomy when sigmoid is part of the colon? Shouldn't a partial colectomy code be used?	No, by definition a total is taking the most or all of the colon. In this example, only 57 cm of the colon is left of 150 cm. This is an appropriate code.
Patient has an existing, malfunctioning PEG which is removed by snare and a new PEG is placed endoscopically - what's your recommendcation for properly coding?	Since snare techniques are only mentioned in the decscriptors of removing a tumor, polyp, or lesion, I am comfortable reporting the removal of a foreign body with the placement of the new PEG as 43246 and 43247. I am still trying to see if there is other guidelines for this.
Can we also use the dentate line (above or below) to determine internal vs external hemorrhoids?	Since the definition of internal hemorroids is that you can not see or feel them, and extenal can easily be seen and observed, I feel that is appropriate.

When would we use the virtual colonoscopy code?	If I understand this right, you would use the virtural code when there is ONLY a screening done, nothing removed or biopsied. You are only visualizing the colon!!
Physician states he performs a colonoscopy through rectum to visualize hartman anastomosis and then colonoscopy via stoma to visualize the bowel before performing a closure. this is outside the 90 day post op. Shouldn't the colonoscopy via rectum really be a flex sigmoidoscopy since the anastomosis is always low, below splenic flexure.	Yes, I totally agree with this. The rationale is solid as to how far the scope really went. By definition, below the flexture is a sigmoid.
The course just reported that when a snare polypectomy and cold biopsies are performed that it should be reported as 45385, 45384-59. 45384 is a hot biopsy code. Cold biopsy should be reported as 45380 (with the 59)	Dr. Pennington, thank you for that. I will research the rest of your question. Do you have an email I can use?
When does cancer become a personal history?	When the patient has been free of any signs of cancer for three years or more. A patient is considered "cured" if it has been seven years or more.
On slide 34 there are 3 polypectomies but only 2 are coded. Would 45380-59 be appropriate for the polypectomy done by cold biopsy forceps?	Yes, that is correct.
Why does diagnosis code Y92.019 have only 6 digits?	External causes, which this is an example of only go to 6 digits.
Your slide 34 colonoscopy examples removed 3 polyps, one via bipolar cautery, cold forceps and snare technique. Where does cold forceps removal falls in under. Does falls under 45384 or should this be reported 45381 in addition to 45384 and 45385?	45380-59 is the last code, for the cold forceps. The snare is included in the other code. This is being corrected. Thank you for the heads up.