

1. **Frequently used CPT Codes:**

- a. 46221: Ligation of Hemorrhoid by rubber band
- b. 46600: Diagnostic Anoscopy (requires modifier 59 when billed with CPT 46221)
- c. 45300: Proctoscopy (requires modifier 59 when billed with CPT 46221)
- d. A4550: Surgical/Supply Tray
- e. Office Visit E&M/Consultation codes: 99201-99205, 99211-99215, 99241-99245 (requires modifier 25 when billed with a procedure)
- f. Effective March 1, 2020, payment for telehealth E/M codes 99441-99443 are equivalent to 99212-99214 and can be used for new and established patients during the PHE. (Must use modifier 95)

2. **Global Period:** The ligation (CPT 46221) has a 10 day global period. When counting out the global period, you should count 12 days from the date of treatment to be conservative. Treatment protocol recommends treating one hemorrhoid per setting in order to minimize complications. For simplicity, we treat patients at two week intervals (or longer) to accommodate the global period.

3. **Anoscopy Coding:** Though you may code for both the anoscopy and the ligation, realize that they are bundled NCCI edits and Medicare, along with any other commercial payors that utilize the NCCI edits for reimbursement methodology, will deny the anoscopy and only pay for the ligation. *As not all commercial payors use the NCCI edits for their reimbursement decisions, there will likely be payors you work with that will allow the codes to be billed together and will reimburse you for the anoscopy, provided a 59 modifier was appropriately applied to the lesser code. As you bill out the code pair you will be able to determine which of your local payors will reimburse for the multiple procedure and which will not.

4. **Surgical Tray:** In the office setting, a surgical tray/supply code (A4550) may be coded for as well, but again, it will frequently be denied as included in the main procedure. As you receive insurance determinations you will learn who will reimburse for the surgical tray.

5. **Office Visit (E&M) Coding:** If you are seeing a patient in the office as a new patient or follow-up, you may code for the new or established patient office visit along with the banding (CPT 46221) as long as you are treating a separate and distinct problem in addition to the patient's hemorrhoids, and if you document that you are addressing these problems. These secondary diagnoses typically include anal spasm, anal fissure, IBS, constipation, diarrhea, skin rash (yeast), etc. You will need to apply modifier 25 to the office visit E&M CPT code when submitting the claim.

6. **Place of Service:** The ligation procedure is versatile and can be performed and reimbursed in the physician office, surgery center or any combination of the two. The procedure can also be performed in combination with a scheduled colonoscopy.

7. **ASC Facility Fee:** If you will be performing the procedure in an ASC setting you will want to make sure CPT Code 46221 is listed on the facility allowed list with each of your insurance contracts to ensure you will be able to recoup the allowed facility fee. Currently, TRICARE is the only payor we are aware of that, nationwide, has not allowed the procedure to be performed in a facility as they have not added it to their facility allowed list, which Medicare and nearly all other commercial insurance carriers have done.

8. **Establishing Standard Charge:** We are frequently asked to assist in establishing the total charge your practice should use with CPT Code 46221. Ultimately, an insurance payor will not reimburse more than your standard charge, even if you have a contractually negotiated rate that is higher. It is very important to ensure that the standard charge you establish is above your highest insurance reimbursement. Charges can be based on any methodology you choose (i.e. RVU's, a multiple of Medicare etc.). Nationally, the average charge submitted to Medicare for CPT code 46221 is approximately \$280.00.

9. **Cash Pay Rates:** Establishing costs for the uninsured or cash pay patient is very practice specific and a variety of factors should be considered, including geographic location and the demographic profile of your particular patient population. We have seen cash pay rates set at 100% of standard charges down to 50% of the standard charge, including additional discounts for paying up front at time of service.

10. **Payor Reimbursement:** Due to the confidential nature of insurance contracts and the variability in reimbursement from one state to the next and contract to contract, we are unable to determine what your typical reimbursement will likely be. It is highly recommended you review your negotiated contracts or query your insurance plans to determine your expected reimbursement for these CPT codes to determine what reimbursement level you can expect to receive.

11. **Pre-Cert/Referral:** Though the procedure does not typically require pre-certification, pre-authorization or a referral we recommend verifying this information prior to the patient's first visit, as some plans will require one.

DISCLOSURE: The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payor. We strongly recommend that providers consult their Payor organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise, or guarantee by CRH Medical Corporation concerning levels of reimbursement, payment or charge. Similarly, all CPT HCPCS and ICD-9 codes are supplied for information purposes only and represent no statement, promise, or guarantee that these codes will be appropriate or that reimbursement will be made. It is the responsibility of the health services provider to confirm the appropriate coding required by their local Medicare carriers, fiscal intermediaries, and commercial payors.