2013 CPT Coding Updates

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The AGA, ACG and ASGE work closely together to ensure that adequate methods are in place for gastroenterology practices to report and obtain fair and reasonable reimbursement for procedures, tests and visits. The society advisors continuously review Current Procedural Terminology (CPT) and work through the AMA process to revise and add new codes as appropriate.

The society advisors would like to thank Kathleen Mueller for her contribution to the development of this coding update.

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Several changes were made to the CPT codes used to report gastroenterology services for 2013 based on the work of the GI societies and their advisors through the AMA’s CPT process. The changes are included in the CPT 2013 codebook and are outlined below.

**New CPT codes for optical endomicroscopy**

Two new codes were added to report optical endomicroscopy when performed with esophagoscopy and esophagogastroduodenoscopy (EGD).

Code 43206 was added to the esophagoscopy family to describe real-time therapeutic decisions involved in optical endomicroscopy procedures when performed with esophagoscopy. This procedure includes the diagnostic injection for the administration of the contrast agent, interpretation and report for the service. The supply of the contrast agent itself, however, is not included as part of the procedure. Therefore, a parenthetical note has been included that directs separate report of the agent. Provision of this service includes the interpretation and report for the service; code 88375 should not be reported in conjunction with this code.

- **43200** Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
  - **43206** with optical endomicroscopy
    (Report supply of contrast agent separately)
    (Do not report 43206 in conjunction with 88375)

Code 43252 was added to the EGD family to describe real-time therapeutic decisions involved in optical endomicroscopy procedures when performed with EGD. The procedure includes diagnostic injection for the administration of the contrast agent and the interpretation and report for the service. The supply of the contrast agent itself, however, is not included as part of the procedure. Therefore, a parenthetical note has been included that directs separate report of the agent. Provision of this service includes the interpretation and report for the service and code 88375 should not be reported in conjunction with this code.

- **43235** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
  - **43252** with optical endomicroscopy
    (Report supply of contrast agent separately)
    (Do not report 43252 in conjunction with 88375)
    (For biopsy specimen pathology, use 88305)
Deleted code for simple primary examination, upper gastrointestinal endoscopy

Code 43234 has been deleted and replaced by 43235. Code 43234 was originally established for reporting upper gastrointestinal panendoscopy using a small-diameter endoscope. However, this approach is not highly utilized, with most patients receiving the service identified by code 43235. A parenthetical note has been added to direct users to report code 43235 to identify upper gastrointestinal endoscopy.

- **43234** Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
  (43234 has been deleted. To report, use 43235)

- **43235** Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

New CPT and health-care common procedure coding system (HCPCS) codes for reporting preparation of fecal microbiota

Code 44705 has been established for reporting the physician work provided for assessing donors and overseeing preparation of fecal microbiota for transplantation for conditions such as *Clostridium difficile*.

- **44705** Preparation of fecal microbiota for instillation, including assessment of donor specimen
  (Do not report 44705 in conjunction with 74283)
  (For fecal instillation by oro-nasogastric tube or enema, use 44799)

Code 44705 inherently includes: (1) development of the slurry that will be instilled into the recipient digestive tract, and (2) assessment of the donor specimen, including physician review of the results of testing the donor’s specimen for infectious pathogens. Laboratory testing provided for the patient is separately reported. Parenthetical notes have been added indicating that code 44705 should not be reported with therapeutic anemia code 74283. A cross-reference has also been added to direct users to code 44799 for fecal instillation via oro-nasogastric tube or enema.

For Medicare, CMS has created a new HCPCS code for preparation of fecal microbiota. Code G0455 includes the physician work for assessment of donors, preparation of fecal microbiota and instillation.

- **G0455** Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen

When this service is provided to a Medicare beneficiary, HCPCS code G0455 should be billed instead of code 44705. Code G0455 includes both the work of preparation and instillation of the microbiota by any method.

In the Physician Fee Schedule Final (PFS) Rule for fiscal year (FY) 2013, CMS stated “Within Medicare,
payment for the preparation of the donor specimen would only be made if the specimen is ultimately used for the treatment of a beneficiary as Medicare is not authorized to pay for any costs not directly related to the diagnosis and treatment of a beneficiary. Because of this policy, we believe it is appropriate to bundle the preparation and instillation into one payable HCPCS code.”

New code for wireless motility capsule; revised codes for capsule endoscopy

Code 91112 was added for wireless capsule motility. Code 91112 replaces code 0242T, Gastrointestinal tract transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report. New parentheticals have been added to 91111 to direct users to code 91112 for gastrointestinal tract transit and pressure measurements taken from the stomach to the colon via wireless capsule. A parenthetical cross-reference in place of deleted code 0242T alerts users to the appropriate code to report for this procedure.

- **91110** Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report
  
  (Visualization of the colon is not reported separately)
  (Append modifier 52 if the ileum is not visualized)

- **91111** Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus with physician interpretation and report
  
  (Do not report 91111 in conjunction with 91110)
  
  (For measurement of gastrointestinal tract transit times or pressure using wireless capsule, use 91112)

- **91112** Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report
  
  (Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)

New transitional care management codes

In response to the July 2011 notice of proposed rulemaking, the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee created the Chronic Care Coordination Workgroup (C3W) to specifically address the CMS request to ensure that care coordination services were described and valued within the evaluation and management services (E/M). The C3W requested that CPT consider creation of codes to describe transitional care management and monthly complex chronic care coordination services.

For 2013, two new CPT codes for transitional care management (TCM), 99495 and 99496, have been added for services provided to patients being discharged from acute, rehabilitation or long-term acute hospital stays into the community. Transitional care management requires a face-to-face visit, initial patient contact and medication reconciliation within specified time frames.

- **99495** Transitional care management with the following required elements:
• Communication (direct contact, telephone, electronic with the patient and/or caregiver within two
  business days of discharge)
• Medical decision making of at least moderate complexity in the service period
• Face-to-face visit within 14 days of discharge

**99496** Transitional care management with the following required elements:

• Communication (direct contact, telephone, electronic with the patient and/or caregiver within two
  business days of discharge)
• Medical decision making of high complexity in the service period
• Face-to-face visit within seven days of discharge

Transitional care management services are for a patient whose medical and/or psychosocial problems
require moderate or high complexity medical decision making during transitions in care from an inpatient
hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial
hospital, observation status in a hospital, or skilled nursing facility/ nursing facility, to the patient’s
community setting (home, domiciliary, rest home or assisted living). Transitional care management
commences upon the date of discharge and continues for the next 29 days.

The TCM codes can be reported by a physician or other qualified health-care professional and/or licensed
clinical staff under the physician’s direction. The codes include one face-to-face visit with the patient after
discharge and the non-face-to-face care provided during the service period. If more than one face-to-face
visit occurs within the reporting period, that visit should be reported separately.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified
health-care professional, may include:

• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two
  business days of discharge.
• Communication with home health agencies and other community services utilized by the patient.
• Patient and/or family/caretaker education to support self-management, independent living and
  activities of daily living.
• Assessment and support for treatment regimen adherence and medication management.
• Identification of available community and health resources.
• Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health-care provider may include:

• Obtaining and reviewing the discharge information (for example, discharge summary, as available, or
  continuity of care documents).
• Reviewing need for or follow-up on pending diagnostic tests and treatments.
• Interaction with other qualified health-care professionals who will assume or reassume care of the
  patient’s system-specific problems.
• Education of patient, family, guardian and/or caregiver.
• Establishment or reestablishment of referrals and arranging for needed community resources.
• Assistance in scheduling any required follow-up with community providers and services.
Only one individual may report these services and only once per patient within 30 days of discharge. Another transitional care management service may not be reported by the same individual or group for any subsequent discharge(s) within the 30 days. The same individual may report hospital or observation discharge services and transitional care management. The same individual should not report transitional care management services provided in the post-operative period for a service with a global period.

A physician or other qualified health-care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340, 99374–99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366–99368), education and training (99600–99602, 99071, 99078), telephone services (99666–99668, 99441–99443), end stage renal disease services (90951–90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), complex chronic care services (99487–99489), or medication therapy management services (99605–99607), during the time period covered by the transitional care management services codes.

**New complex chronic care codes**

Three new codes for complex chronic care coordination have been added for 2013. Codes 99487–99489 are reported only once per calendar month and include all non-face-to-face complex chronic care coordination services and none or one face-to-face office or other outpatient, home or domiciliary E/M visit related to care for the patient’s chronic condition(s).

- **99487** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health-care professional with no face-to-face visit, per calendar month
- **99488** First hour of clinical staff time directed by a physician or other qualified health-care professional with one face-to-face visit, per calendar month
- **99489** Each additional 30 minutes of clinical staff time directed by a physician or other qualified health-care professional, per calendar month

(List separately in addition to code for primary procedure)

The complex chronic care coordination services described by these codes involve clinical staff implementing a plan of care established and directed by a physician or other qualified health-care professional. These codes include all non-face-to-face complex chronic care coordination services and may include one face-to-face office or other outpatient, home or domiciliary evaluation and management visit related to care for the patient’s chronic conditions.

Complex chronic care coordination services are:

- Patient-centered management and support services provided by physicians, other qualified health-care professionals (QHCP) and clinical staff.
- Provided to an individual residing in a home or in a domiciliary, rest home or assisted living facility.
- A care plan directed by a physician or QHCP and typically implemented by clinical staff.
- Services that address the coordination of care by multiple disciplines and community service agencies.
The reporting individual provides or oversees the management and/or coordination of services, as needed, for:

- All medical conditions.
- Psychosocial needs.
- Activities of daily living.

Patients requiring complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (e.g., predictive modeling risk score or repeat admissions or emergency department use) or clinical judgment.

Complex chronic care coordination services patients:

- Typically have one or more chronic continuous or episodic health conditions.
- Commonly require the coordination of a number of specialties and services.
- May have medical and psychiatric behavioral co-morbidities complicating their care.
- May have social support weaknesses or access to care difficulties.

Complex chronic care coordination services codes 99487–99489:

- May only be reported once per calendar month.
- Include all non-face-to-face CCCC services.
- Include none or one face-to-face office or other outpatient, home or domiciliary visit.
- May only be reported by the single physician or other QHCP who assumes the care coordination role with a particular patient for the calendar month.

A parenthetical note following the complex chronic care coordination services codes indicates several excluded codes from both the E/M and medicine sections. Codes 99487–99489 cannot be reported during the same month as any of the excluded codes. Extensive section guidelines were also added to instruct on the use of the new codes.

On an interim final basis for calendar year (CY) 2013, CMS has assigned CPT codes 99487, 99488 and 99489 a PFS procedure status indicator of B (payments for covered services are bundled into payment for other services) and are not separately payable. The gastroenterology societies are working collaboratively with other specialty societies to urge CMS to accept the RUC recommended values for the complex chronic care coordination services codes for the 2014 PFS, and to allow reporting of the complex chronic care coordination services codes by specialists, as well as primary care physicians.
General changes to CPT 2013

Provider Neutrality
The 2013 revisions to introductory guidelines throughout CPT continue the process of updating CPT to more provider neutral nomenclature. Most procedures now reference services performed by a physician or “other qualified healthcare professional” or have other provider-neutral language.

New vs. Established Patients
CPT has added additional clarification to the new vs. established patients reporting guidelines when these services are performed by advance practice nurses or physician’s assistants (PA). Per CPT, “In the instance where a physician/qualified health care professional (QHCP) is on call for or covering for another physician or QHCP, the patient’s encounter will be classified as it would have been by the physician or QHCP. When advanced practice nurses and PA are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.”

Time
CPT has provided additional commentary on the impact of time with regards to the selection of E/M services. The guideline is stated as follows: “…specific times expressed in the visit code descriptors are averages and, therefore represent a range of times that may be higher or lower depending on actual clinical circumstances.”

Additionally, CPT has clarified that time is not used to select for emergency department code levels due to:

• Variability of intensity.
• Potential for multiple encounters with several patients over time.

Initial Observation and Hospital Care
CPT has clarified instructions for reporting admissions to observation and inpatient hospital care. When the admission to observation or inpatient status occurs following an encounter in another site of service, all E/M services provided are considered part of the observation/inpatient admission care when they are performed on the same date. The level of service selected should reflect all of the services provided relating to initiating the admission.

Subsequent Observation and Hospital Care
The documentation guidelines for reporting subsequent observation and subsequent hospital care have been clarified with the addition of the following information.

All levels of subsequent care include:

• Reviewing the medical record.
• Reviewing results of diagnostic studies.
• Reviewing changes in the patients’ status (i.e., history, physical condition and response to management) since the last assessment.
Admission to Observation and Discharge on the Same Date

CPT guidelines for observation or inpatient care services (including admission and discharge services) now explicitly state that when a patient is admitted to the hospital (inpatient status) from observation status on the same date, only the initial hospital care code should be reported. The provider should include all services related to the observation services performed in the level of service selected for the initial hospital care code.

Evaluation & Management

Most changes involve the addition of “qualified health care professional” into the description of every E/M code. However, 2013 CPT did add some advice regarding “time” billing. Listed below in highlighted text are the excerpts:

- **Face-to-face time (office and other outpatient visits and office consultations):** For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, performing an examination, and counseling the patient. Time is also spent doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

- **Unit/floor time (hospital observation services, inpatient hospital care, initial inpatient hospital consultations, nursing facility):** For reporting purposes, intraservice time for these services is defined as unit/floor time, which includes the time present on the patient’s hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient’s chart, examine the patient, write notes, and communicate with other professionals and the patient’s family.

Although most of the visits submitted for payment are based upon the three elements of history, physical exam and decision making, there are times when counseling and coordination of care encompasses the majority of the visit. In those situations, billing by time should be the driving factor provided that time is documented in the progress note. Documentation should indicate the total number of minutes with the amount of counseling time specified. With the advent of the “time stamp” feature in the medical record, this does make it easier to calculate time.

When to use time as basis for the visit:

- **Discussion with patient and/or family with regards to:**
  - Diagnostic results, impressions, and/or recommended studies.
  - Prognosis.
  - Risks and benefits of management or treatment options.
  - Instructions and/or follow up.
  - Importance of compliance with chosen treatment or management options.
  - Risk factor reduction.
  - Patient and family education.
  - Usually not the basis for initial patient visits.
• Proper examples of time documentation:
  – “I spent a total of 30 of 45 minutes on the floor coordinating David’s care and in discussion with David regarding…”
  – “Thirty of 40 minutes of visit with Mary and her family were spent discussing…”
  – The entire 20 minute visit was spent discussing new diagnosis of Crohn’s disease found during colonoscopy last week. All questions were answered. Discussion included...

• Face-to-face time with patient minutes.

  Time spent in counseling and/or coordination of care _______ minutes.

  Discussion: ______________________________________________________

• Improper examples of time documentation:
  – Extensive discussion was done with the patient and family concerning…
  – Twenty minutes was spent with the patient…

## Time thresholds

<table>
<thead>
<tr>
<th>OFFICE NEW PATIENT/OBSERVATION CARE VISIT</th>
<th>OFFICE/OUTPATIENT CONSULTATION</th>
<th>OFFICE ESTABLISHED PATIENT/OBSERVATION FOLLOW UP VISIT</th>
<th>INPATIENT CONSULTATION</th>
<th>INPATIENT FOLLOW-UP VISIT OR OBSERVATION FOLLOW UP VISIT</th>
<th>INITIAL INPATIENT CARE</th>
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<td>99201–10 minutes</td>
<td>99241–15 minutes</td>
<td>99211–5 minutes</td>
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<td>99215–40 minutes</td>
<td>99255–110 minutes</td>
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</table>
New Category III Codes

Six new category III codes 0312T–0317T have been added to report laparoscopic vagus nerve blocking therapy for treatment of obesity. The descriptors denote the anatomic placement, revision/replacement, and removal of the vagal trunk neurostimulator electrode array and/or pulse generator.

- **0312T** Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming
- **0313T** Laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
- **0314T** Laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator
- **0315T** Removal of pulse generator
- **0316T** Replacement of pulse generator
- **0317T** Neurostimulator pulse generator electronic analysis, includes reprogramming when performed

Common GI Coding and Billing Questions

**KATHLEEN MUELLER, RN, CPC, CCS-P, CMSCS, CCC, PCS**

**Question and answer forum:**

**Question** When billing for snare polypectomy in the sigmoid colon using a cold snare, what CPT code should be submitted for payment?

**Answer** The code 45385 [colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique], does not indicate the brand name, type or whether it is cold or hot technique. Therefore, 45385 is appropriate for billing polypectomy using snare instrumentation.

**Question** My doctor changes a gastrostomy tube and then adds an extension into the jejunum, what code do we use?

**Answer** If the g-tube is changed and then, with the use of endoscopy, an extension is added and guided into the jejunum, there are two codes that would be used, 43760 for the g-tube and 44373 for endoscopic conversion of gastrostomy to jejunostomy.

**Question** How do you bill for dilation of a gastrojejunostomy? There is no CPT code that matches that description.

**Answer** Gastrojejunostomy is considered the gastric outlet for patients that have had some sort of intestinal bypass whether for neoplasms, bariatric surgery, or other GI disorders. You would use the CPT code of 43245 for EGD with dilation of gastric outlet obstruction.
ICD-9 Code freeze and preparation for ICD-10


The ICD-9/ICD-10 Coordination and Maintenance Committee has instituted a partial code freeze in response to payor, provider and vendor concerns about the difficulty of maintaining the code sets during ICD-10 implementation. The coordination and maintenance committee has announced the following update to the code freeze schedule to coordinate with the new compliance timetable as it is outlined in the final rule:

Schedule for Partial Freeze of Revisions to ICD-9-CM and ICD-10-CM/PCS

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on Oct. 1, 2011.
- On Oct. 1, 2012, and Oct. 1, 2013, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On Oct. 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On Oct. 1, 2015, regular updates to ICD-10 will begin.
Understanding the RUC Survey Process

When Medicare transitioned to a physician payment system based on the Resource-Based Relative Value Scale (RBRVS), the AMA formulated a multi-specialty committee, known as the AMA RVS Update Committee (RUC). The RUC has made numerous recommendations to CMS that have significantly affected the Medicare physician payment schedule by giving physicians a voice in shaping Medicare relative values. The RUC, in conjunction with the Current Procedural Terminology Editorial Panel, has created a process through which specialty societies can develop relative value recommendations for new and revised codes. The RUC carefully reviews survey data presented by specialty societies and develops recommendations for consideration by CMS. AGA and ASGE are active participants in the RUC.

The RUC’s recommendations are based on data collected from surveys of practicing physicians regarding the time, intensity and complexity of new and revised CPT codes. But, the RUC process cannot work without you. Do not forfeit this important opportunity to provide direct input into the valuation of endoscopy services.

To volunteer to participate in the survey process, email surveys@asge.org with your name and contact information. Based on the list of surveys below, please specify which procedure surveys apply to you. Additional information will be provided prior to the start of each survey.

The Survey Process Requires Physician Input

For the RUC survey process to succeed, the cooperation and participation of practicing physicians is essential. It is only with your input that we can provide the RUC and CMS with accurate data so gastroenterology services can be fairly valued by Medicare. Many private insurers base their rates on a percentage of Medicare, resulting in a wide and significant impact of this process.

Our societies need to expand our database of practitioners who are able to complete the work surveys we use to recommend RVUs for procedures, including both existing codes under review and new codes that may come up in the future. Gastroenterologists who perform routine procedures, such as colonoscopy and esophagogastroduodenoscopy (EGD), and more complex procedures, such as endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasound (EUS), are needed.

We recognize that practicing physicians are faced with increasing demands on their time, but we believe this is an important, valuable and unique opportunity for any practicing gastroenterologist. By participating in a RUC survey, you will be able to have direct input on the valuation of the services you provide.

If you are contacted via email to participate in RUC surveys, we urge you to complete them. If you are able to assist, please RSVP to surveys@asge.org as soon as possible and include your name, email address and practice location.
The Endoscopy Survey Timeline

<table>
<thead>
<tr>
<th>Procedure Family</th>
<th>Code Range</th>
<th>Survey Date</th>
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<tbody>
<tr>
<td>Esophagoscopy</td>
<td>43200–43234</td>
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<tr>
<td>Esophageal Dilation</td>
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<tr>
<td>EGD</td>
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<td>ERCP</td>
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<td>Enteroscopy to ileum</td>
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<tr>
<td>Colonoscopy</td>
<td>45378–45392</td>
<td>Fall 2013</td>
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</tbody>
</table>

The Basics of the RUC Survey Process

When new codes are established or existing codes are revised, a survey of physicians providing that service is conducted by the relevant medical specialty society. The purpose of the survey is to measure physician work involved in performing the procedure to determine an accurate relative value recommendation for the service. AGA and ASGE conduct surveys for gastroenterology services, analyze the results and present recommendations to the RUC.

The AMA defines physician work as:

- Physician time it takes to perform a service.
- Physician mental effort and judgment.
- Physician technical skill and physical effort.
- Physician psychological stress that occurs when an adverse outcome has serious consequences.

In May of every year, the RUC submits its recommendations to CMS. In the summer, through the federal regulations process, CMS publishes proposed work values. After the public comment process, the new values are finalized and implemented on Jan. 1 of the following year.

Read more about the RUC.
View a webinar which describes how to take the survey.
Download a PDF presentation on understanding the survey instrument.
Read the RUC Survey Instrument FAQs