2026 CPT®
Coding Updates

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2026 CPT Coding Update

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and American Society for Gastrointestinal Endoscopy (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 societies' advisors continuously review Current Procedural Terminology (CPT®) and work through the AMA process to revise and add new codes, as appropriate. Our societies have prepared the 2026 CPT Coding Update on issues of interest to gastroenterologists.

2026 GI CPT Changes

The American Medical Association (AMA) 2026 CPT changes include several new codes impacting gastroenterologists that will take effect Jan. 1, 2026.

New Endoscopic Sleeve Gastroplasty Code

New CPT code 43889 is used to report transoral endoscopic sleeve gastroplasty, including argon plasma coagulation when performed. The code is located in the "Other Procedures" section following bariatric surgery codes.

- **43889:** Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed

Do not report 43889 with 43191 (rigid, transoral esophagoscopy), 43197 (flexible, transnasal esophagoscopy), 43200 (flexible, transoral esophagoscopy), 43235 (EGD)

Code 43889 has a 90-day global period, meaning all follow-up E/M care associated with the surgery within that time is included in the payment for the code, but other visits focusing on other GI issues or non-endoscopic obesity management could be reported using 24 modifier.

Colon Motility Testing Codes Updated

Changes were made to the colon motility tests to update the code descriptors and work to reflect current practice. To avoid confusion, former codes 91120 and 91122 were deleted and replaced with new codes:

- **91124:** Rectal sensation, tone and compliance study (e.g., barostat)
- **91125:** Anorectal manometry with rectal sensation and balloon expulsion test, when performed

Do not report 91124 in conjunction with 91117 (colon motility study) or 91125. Do not report 91125 in conjunction with 91117 or 91124

Both codes have XXX-day global periods, allowing same-day E/M services when appropriate.

New Category I Code Established for PENFS

The temporary Category III code for percutaneous electrical nerve field stimulation has been replaced with CPT code 64567.

- **64567:** Percutaneous electrical nerve field stimulation, cranial nerves, without implantation

The service describes periauricular placement of a non-implanted electrical nerve field stimulator for treatment of chronic IBS abdominal pain. Treatment typically involves weekly device placement over four weeks.

Code 64567 has an XXX-day global period, allowing same-day E/M services when appropriate. However, reporting an E/M on the same day is not typical. Circumstances for separately reporting an E/M code include:

- When extended history and medical decision making is performed on the same day as the PENFS device is placed, which might happen if the patient was referred to you from another specialist for consideration of PENFS treatment
- If there has been a significant time between when the decision was made to place the PENFS and the day of the procedure.
- On the last day of treatment, if additional discussions and medical decision making occur to outline next steps.

Outpatient E/M Update

January 1, 2026, marks the 5th anniversary of the guideline changes to the outpatient E/M codes. It's a good time to review key requirements for documenting and selecting E/M code levels to ensure you're getting paid appropriately for your services.

Selecting E/M Levels of Service Based on Time

When selecting levels of service based on time, remember the total time on the date of the encounter and includes both face-to-face time with the patient and services personally provided before and after the patient encounter. E/M codes have a required threshold time that must be met and documented in the record.

Key Reminders:

- Time includes the time on the date of the encounter preparing to see the patient, obtaining a history, performing an exam, communicating with other providers, personally ordering tests and medications and documenting in the medical record.
- Time spent performing separately reported procedures does not count towards the E/M level of service.

Selecting E/M Levels of Service Based on MDM

MDM is defined by 3 elements which are used to determine the overall level of MDM. The CPT Codebook includes a Table of MDM to assist in the selection of the level of MDM. To qualify for a level of service, two of the three elements must be met or exceeded. The following are the elements and key reminders when selecting the level of MDM:

- Number and Complexity of Problems Addressed at the Encounter
    - o Remember to document the status of the illness in either the history or plan of care to provide support for the determining the level of MDM for this element. For example:
        - A stable chronic illness is defined as meeting the patient's individual treatment goal and is considered low MDM (level 3)

      BUT
        - If the patient is not meeting treatment goals or is experiencing side effects of treatment or progression of disease, then the problem type corresponds to moderate MDM (level 4)
- Amount and Complexity of Data to be Reviewed and Analyzed
    - o Remember to document the review of outside records, discussions with other providers and any independent interpretation of tests.
    - o Each unique test, order or document contributes to the MDM level and can be combined to determine the level of this element
    - o Discussions of management or test interpretation with an outside provider or independent interpretation of tests raises the MDM to moderate (level 4) even if there are no other data elements
- Risk of Complications and/or Morbidity or Mortality of Patient Management
    - o Remember to document all current treatments and plans for further testing or procedures including any identified risk factors associated with the patient or the treatment(s)
    - o Management risk is based on the usual behavior and thought processes of physicians/QHPs in the same specialty and is separate from the risk of the problem
    - o For MDM, the level of risk is based on the consequences of the problem addressed at the encounter when appropriately treated and addressed as part of the reported encounter