2017 CPT®
Coding Updates

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2017 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.

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Coding Updates

CATEGORY I CODE CHANGES

Moderate Sedation

The Centers for Medicare and Medicaid Services (CMS) announced in 2014 that the value of moderate sedation services will be separated from procedure codes in all specialties, including almost all gastrointestinal endoscopy procedures, in which the underlying service was originally valued with moderate sedation. CMS noted that anesthesia services (propofol administered by other than the endoscopist) were increasingly being separately reported for endoscopic procedures. As a result, the resource costs associated with sedation were no longer being incurred by the practitioner reporting the procedure, but were still included in the reimbursement of the procedure. To address this issue, the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel created separate CPT codes for administration of moderate sedation. CMS created a separate Healthcare Common Procedure Coding System (HCPCS) code for moderate sedation administered by the provider for most GI endoscopic procedures.

Intra-service time of moderate sedation is used to select the appropriate code(s), which differs from the time of the procedure the sedation supports. For these purposes, "intra-service" time of moderate sedation:

- ***Begins with the administration of the sedating agent(s);***
- ***Ends when the procedure is completed, the patient is stable for recovery status, and the physician or other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient;***
- Includes ordering and/or administering the initial and subsequent doses of sedating agents;
- Requires continuous face-to-face attendance of the physician or other qualified health care professional;
- Requires monitoring patient response to the sedating agents, including:
    - o Periodic assessment of the patient;
    - o Further administration of agent(s) as needed to maintain sedation; and
    - o Monitoring of oxygen saturation, heart rate, and blood pressure.

If the physician or other qualified health care professional who provides the sedation services also performs the procedure supported by sedation (99151, 99152, 99153), the physician or other qualified health care professional will supervise and direct an independent trained observer who will assist in monitoring the patient's level of consciousness and physiological status throughout the procedure.

Moderate sedation codes 99151, 99152, 99153, 99155, 99156, 99157 are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999).

CMS requires reporting of the new moderate sedation codes, and has removed the associated value from the majority of endoscopic procedures (0.10 wRVU). Report G0500 for all endoscopic procedures where moderate sedation was previously considered inherent to the procedure for the initial 15 minutes of moderate sedation.

CPT/HCPCS CODE	DESCRIPTION
Moderate Sedation Provided by the Same Provider	
G0500	Moderate sedation services provided by the same physician or other qualified health-care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older.
99151	Moderate sedation services provided by the same physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra- service time, patient younger than 5 years of age.
99152	Moderate sedation services provided by the same physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra- service time, patient younger than 5 years of age.
+99153*	Moderate sedation services provided by the same physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra- service time (List separately in addition to code for primary service).
Moderate sedation provided by a different physician	
99155	Moderate sedation services provided by a physician or other qualified health-care professional other than the physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age.
99156	Moderate sedation services provided by a physician or other qualified health-care professional other than the physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older.
+99157*	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

*+99153 and +99157 contain PE inputs only (i.e., equipment, supplies and staff associated with the provision of moderate sedation) carries no reimbursement outside of the office site of service.

Note that propofol sedation provided by anesthesia professionals is seldom going to be reported with moderate sedation codes, since such sedation is typically deep sedation, reported presently by anesthesia codes 00740 for the upper GI procedures, and 00810 for the colon or ileooscopy procedures.

Use G0500 with all GI Endoscopy CPT Codes for Medicare patients?

For Medicare patients, nearly all endoscopy services are reported with G0500 if the endoscopist provides moderate sedation. The only exceptions are three codes in the EGD family (43266, 43270, and 43273) that we believe CMS overlooked in their table in the final rule, and which we believe will be remedied sometime in 2017. The other exceptions are the codes for flexible sigmoidoscopy, diagnostic and biopsy, where moderate sedation was never valued as being inherent to the procedure, hence has “always” been reported separately. In these instances, report moderate sedation with 99152 for patients over 5 for the initial 15 (10 to 22) minutes.

Report G0500 for Medicare patients (>5 years old) for ALL GI ENDOSCOPY CODES EXCEPT:

43266	No but appears to be CMS oversight and will become YES during 2017
43270	No but appears to be CMS oversight and will become YES during 2017
43273	No but appears to be CMS oversight and will become YES during 2017
45330	No. If moderate sedation is performed, report separately with CPT 99152 991529…99152 for patients aged 5+99152 for patients aged 5+
45331	No. If moderate sedation is performed, report separately with CPT 99152 for patients aged 5+

Other non-endoscopic services e.g. 43450 (bougie dilation) report with 99152 for age over 5 years old.

Total Intra-service Time for Moderate Sedation provided by endoscopist.

CPT published a table which guides the actual minutes that distinguish 99152/G0500 from the add-on “additional 15 minutes,” which reflects a CPT convention that for time-based codes, the threshold to report a unit of time is ½ the total time of the service. So for a 15 additional minutes of moderate sedation, at least 7 minutes of the additional service must be performed. Since the panel decided that less than 10 minutes of time should not be reported separately, the time breaks for the services wind up as follows:

Less than 10 minutes - not reported separately:

- 10-22 minutes: 99152
- 23-37 minutes: 99152 + 99153
- 38-52 minutes: 99152 + 99153 x 2
- 53-67 minutes: 99152 + 99153 x 3
- 68-82 minutes: 99152 + 99153 x 4
- 83 minutes or longer: add 99153 for every 15 additional minutes to the previous line

Laparoscopy

New codes were added to CPT to report the anti-GERD procedure commonly known as LINX™, replacing category III codes.

- **43280**: Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)

  (Do not report 43280 in conjunction with 43279) (For open approach, see 43327, 43328) (For esophagogastroduodenoscopy fundoplasty, partial or complete, transoral approach, use 43210)

- **43284**: Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed

  (Do not report 43284 in conjunction with 43279, 43280, 43281, and 43282)

New CPT Code for 2017

Ambulatory Payment Classification (APC) Classification	5362
Work RVU	10.13
Total RVU	18.79
National Average Medicare Payment	$674.35

- **43285**: Removal of esophageal sphincter augmentation device

New CPT Code for 2017

Ambulatory Payment Classification (APC) Classification	5361
Work RVU	10.47
Total RVU	19.01
National Average Medicare Payment	$682.24

Category III codes 0392T, 0393T, which described laparoscopic esophageal sphincter augmentation procedures, have been deleted and converted to Category I codes.

Other Category I Code Highlights

Preventive Medicine Services

- **~~99420~~**: Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal). 99420 has been deleted.

To report, see:

- **96160**: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.

Unlisted Services

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

- **99429:** Unlisted preventive medicine service
- **99499:** Unlisted evaluation and management service

CPT Codes That May Be Used For Synchronous Telemedicine Services

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Examples of such services could include encounters that would otherwise require face-to-face visits as follow-up to an initial assessment, or to discuss in detail the results of a procedure like colonoscopy for a newly diagnosed colitis patient regarding future management. When permitted by state regulations related to licensing, a substantial industry now exists to link physicians to new "patients" seeking advice about their symptoms or conditions via telehealth platforms. Services adjunctive to GI physician services now exist in the telehealth world including dietitian consultation (e.g. Gastrogirl™, psychsocial support of IBD patients (e.g. IBD Support Foundation), and TelePsychiatry promoting "mindfulness," an approach found useful for chronic pain and functional GI complaints (e.g. RenewTeleHealthcom™).

Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face, but may be rendered via a real-time (synchronous) interactive audio and video telecommunications system. These services include:

- **0188T:** Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
- **0189T:** Each additional 30 minutes (List separately in addition to code for primary service)
- **96150 - 96154:** Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)
- **97802 - 97804:** Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient
- **98960 - 98962:** Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

- **9201 - 99205:** Office or other outpatient visit for the evaluation and management of a new patient,
- **99212 - 99215:** Office or other outpatient visit for the evaluation and management of an established patient
- **99231 - 99233:** Subsequent hospital care, per day, for the evaluation and management of a patient,
- **99241 - 99245:** Office consultation for a new or established patient
- **99251 - 99255:** Inpatient consultation for a new or established patient,
- **99307 - 99310:** Subsequent nursing facility care, per day, for the evaluation and management of a patient,
- **99354 - 99355:** Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
- **99406 - 99409:** Alcohol, smoking and tobacco use cessation counseling visit; for Medicare patients, consider G0396 orG0397 in place of 99408 or 99409
- **99495 - 99496:** Transitional Care Management Services

Keep in mind that existence of a code doesn't translate into automatic coverage by any specific payer.

Chronic Care Management (CCM) and E/M new Add-on Code

Prolonged Service without Direct Patient Contact

Beginning in CY 2017, CMS will recognize CPT codes 99358 (Prolonged evaluation and management service before and/or after direct patient care, first hour) and 99359 (Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes) for separate payment under the physician fee schedule.

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. *This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.* A typical time for the primary service need not be established within the CPT code set.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous.

Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Medicare does not allow chronic care management (CCM) codes (99487-99489) to be reported during the same month as non-face-to-face prolonged services. Similarly, non-face-to-face prolonged services may not be reported when performed during the service time of transitional care management (TCM) codes 99495 and 99496 (by a single practitioner).

Do not report 99358, 99359 for time spent in care plan oversight services (99339, 99340, 99374-99380), anticoagulant management (99363, 99364), medical team conferences (99366-99368), on-line medical evaluations (99444), or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set. Codes 99358, 99359 may be reported when related to other non-face-to-face services codes that have a published maximum time (e.g., telephone services).

99358: Prolonged evaluation and management service before and/or after direct patient care; first hour

+ 99359: each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99359 in conjunction with 99358)

(Do not report 99358, 99359 during the same month with 99487-99489)

(Do not report 99358, 99359 when performed during the service time of codes 99495 or 99496)

E&M Add-on Code G0506

CMS finalized an add-on code beginning January 2017 when extensive assessment and care planning is required, outside of the usual effort as described by a qualifying evaluation & management (E/M) face-to-face visit, or chronic care management (CCM) initiating visit. G0506 will be a code that is only billable one time. The service represents physician rather than staff work.

G0506 is for Medicare only. Prolonged services, whether face-to-face (CPT 99358) or non-face-to-face (CPT 99359), cannot be reported in addition to G0506 in association with a companion E/M code that also qualifies as the CCM initiating visit. In association with the CCM initiating visit, a billing practitioner may choose to report either prolonged services or G0506 but cannot report both a prolonged service code and G0506. Check with your commercial payers to see if they pay for prolonged services.

+ G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service

Use this code as an add–on code when a patient requires more comprehensive face–to–face assessment of a patient with severe/chronic health issues over and above an initial visit.

(billed separately from monthly care management services)

(Add-on code, list separately in addition to primary service).

Global Surgery Data Collection: For certain GI practices (use CPT 99024)

CMS is required by statute to collect data in order to value global surgical services. Beginning July 1, 2017, practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island are required to report on claims data on post-operative visits furnished during the global period of specified procedures using CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure).

Practices with fewer than 10 practitioners are exempted from required reporting, but are encouraged to report if feasible. Although reporting is required for global procedures furnished on or after July 1, 2017, CMS encourages all practitioners to begin reporting as soon as possible.

Impacted CPT Codes for GI:

46221 Hemorrhoidectomy, internal, by rubber band ligation(s)

46500 Injection of sclerosing solution, hemorrhoids

46930 Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency

CATEGORY II CODES

The CPT contains a set of supplemental tracking codes that can be used for quality reporting and performance measurement. These "category II" codes are intended to facilitate data collection about the quality of care. These codes are also used for Medicare quality reporting under the newly implemented Merit-Based Incentive Payment System (MIPS). More information can be found on the CMS "**Quality Payment Program**" website.

The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I reimbursement codes.

Hepatitis C

4151F: Patient did not start or is not receiving antiviral treatment for Hepatitis C during the measurement period (HEP-C)[PCPI].

The descriptor for code 4151F has been revised to comply with the revision of the Hepatitis C Ribonucleic Acid (RNA) Testing before Initiating Treatment1 measure for which this code is reported. The information within the Alphabetical Clinical Topics Listing has also been revised.

CATEGORY III CODES

Category III codes allow data collection for these services/procedures. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. The use of the codes in this section allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, procedures, and procedures service paradigms for clinical efficacy, utilization and outcomes.

- **0287T: Deleted**

  Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence).

- **0392T: Deleted**

  0392T: Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (e.g., magnetic band).

  (use 43284)

- **0393T: Deleted**

  Removal of esophageal sphincter augmentation device.

  (use 43285)

Appendix O

Multianalyte Assays with Algorithmic Analyses

A variety of laboratories offer proprietary bundles of tests promoted to improve ability to stage liver disease, cancer prognosis , identify pathogens by gene screening of a broad range of tests run simultaneously in lieu of traditional culture or single specific immunologic tests, or for example to guide treatment choices. These services for CPT purposes are being placed in a specific section of CPT.

The following list includes a set of administrative codes for Multianalyte Assays with Algorithmic Analyses (MAAA) procedures that by their nature are typically unique to a single clinical laboratory or manufacturer. MAAA procedures that have been assigned a Category I code are noted in the list below and additionally listed in the Category I MAAA section (81500-81599).The Category I MAAA section introductory language and associated parenthetical instruction(s) should be used to govern the appropriate use for Category I MAAA codes.

Administrative Codes for Multianalyte Assays with Algorithmic Analyses (MAAA)

HCV FibroSURE™ , LabCorp

FibroTest™ , Quest

(ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver.

Diagnotics/BioPredictive

0001M - Infectious disease, HCV, six biochemical assays

Top 10 2017 Coding Questions & Tips

1. QUESTION:

We are seeing payors deny G0105 (colonoscopy for high risk screening/surveillance) with diagnosis code of Z86.010. We are being told that there should be an additional diagnosis, but when I check the website, there isn't any additional diagnosis listed.

Answer: Payors are starting to follow the ICD-10-CM instructions. When the patient has a history of colon polyps or cancer, don't forget to assign Z08 (Encounter for follow-up examination after completed treatment for malignant neoplasm) as the primary diagnosis before history of cancer series Z85.XXX codes and/or Z09 (Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm) as the primary diagnosis before history of colon polyps Z86.010. The Z85 and Z86 series are considered secondary diagnoses to Z08 and Z09. This information may not necessarily be listed in the LCDs (Local Coverage Determinations). However, if your current method of coding for surveillance hasn't encountered claims denials or holdups for further information, adding additional codes isn't necessary.

2. QUESTION:

What type of documentation is required for colonoscopy with endoscopic mucosal resection?

Answer: In order to assign the EMR (Endoscopic Mucosal Resection) codes for colonoscopy (45390), make sure that your physician has the complete technique documented and states that an EMR was done. This should include a submucosal injection, specialized snare technique, and/or ablation. Often, this will be a cap assisted device or ligation-assisted device with demarcation of the lesion. Make sure that your coding software does not just assign the EMR code simply because a saline lift and snare technique was utilized for a colonoscopy procedure. During an EGD, EMR (43254) MAY be reported for a lift and snare technique. If the endoscopy report is not specific, always confirm with your physician to make sure that an EMR was performed.

3. QUESTION:

Since we don't have any anesthesia providers in our endo centers, can physicians bill for anesthesia in addition to the endoscopy when they are supervising and/or administering the anesthesia?

Answer: As of January 1, 2017, they can, at least for moderate sedation. Prior to 2017, anesthesia (moderate or conscious sedation) services by the endoscopist were included in the work RVUs (Relative Value Units) of nearly all of the endoscopy procedures. At least for Medicare, moderate sedation services when provided must be reported separately from the procedure code (see separate article in this Update), and the associated work RVUs have been removed from the procedure (an amount of 0.10 RVU). This means that providers who supervise and/or administer the anesthesia for their patients usually with the assistance of a trained professional (usually an RN) can now bill for these services in addition to the endoscopy. In order to bill for these services, the physicians will have to have anesthesia services documented appropriately. There will have to be a pre-anesthesia risk assessment, diary/log of all anesthesia services and post-anesthesia assessment in order to bill for any of the conscious sedation CPT and/or G codes, which is typically just an aspect of pre and post-endoscopy patient evaluation as it has been traditionally. There is NO CHANGE

in how moderate sedation is provided, supervised or documented, except that the TIME for the service needs to be documented and the service separately reported, with codes for "initial 15 minutes" and if pertinent, "subsequent 15 minutes". Coders will have to review these charges closely before assigning the time driven conscious sedation codes. Within endoscopy units, how the start and end time, thus duration of service, is calculated will need to be established within the overall work flow, in many cases via use of "time tracker" entries in the endo-writer software, in other cases as manual entries by nurses and documentation of time within the procedure report. This could be quite simple, e.g. "mod sed 28 min".

4. QUESTION:

We have been seeing payors request refunds in reimbursement for audited colonoscopy claims when billed and paid as screening procedures that included a symptom on the indication as well as screening. Some are even changing the procedure to diagnostic after auditing the history and physicals and finding that the patient has a symptom. Can they do that?

Answer: Unfortunately, yes they can, provided that, they are reviewing and recouping within the state insurance guidelines published by the State Insurance Commissioner's Office. Per ICD-10 instructions, the code Z12.11 (Encounter for screening for colon malignancy) should only be assigned when the patient is completely asymptomatic and without abnormality. If the patient has a symptom and/or abnormality, that is the diagnosis that should be assigned. If your physician has both screening and a symptom listed on the indications on the colonoscopy report, this should be clarified and amended since a symptom and screening is considered contradictory. If the patient truly does have a GI symptom that does not require endoscopic evaluation, that should not be listed on the indications. If it is listed in the H&P, there should be something next to the symptom to explain that it does not require endoscopic evaluation.

Example: Chronic constipation. Improved with Miralax regimen. Encouraged to drink more water since patient admits that she does not drink as much as she should. Does not require endoscopic evaluation at this time. However, patient is due for a screening colonoscopy and it will be scheduled.

5. QUESTION:

What documentation is required to support 43259 (Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)?

Answer: Since the description includes EUS of all three upper GI sites of esophagus, stomach and duodenum/small intestine, there has to be documentation to support that all of these sites plus any other adjacent sites were examined. Below is an example of supportive documentation.

Example: EUS - Imaging was performed through the esophagus, stomach and duodenum. The subcarinal space and aortopulmonary window appear wnl. The celiac axis and left adrenal gland appear wnl. The confluence of the PV, SV and SMV appear wnl. The pancreatic parenchyma appears wnl. The main PD measured in its maximum diameter 1.8 mm at the body and tail, 2.7 mm at the neck and 4.5 mm at the head. The visualized portions of the left hepatic lobe appear wnl. The CHD measured 3.3 mm in diameter with no evidence of choledocholithiasis or strictures during this examination. The GB was not visualized.

6. QUESTION:

Since October 1, 2016, our denials have increased. We are seeing a new reason code of "diagnosis code lacks specificity". What is going on?

Answer: CMS and most commercial payors instituted a 12-month grace period for accepting diagnosis codes that

lacked specificity. This grace period expired on September 30, 2016. Effective October 1, 2016, payors are more likely to deny claims due to the lack of specificity. If you see that a non-specific diagnosis code is assigned by your providers to any visits or procedures, pull the documentation to check for specificity. Often, the specifics are documented in the history of present illness (HPI) and not assigned in the assessment and plan. Make sure that your software system is updated for lists of favorites per provider and/or group so that choices for ICD-10 codes are reflective of the patient's medical condition and not just straight out of the ICD-10 book. This requires some teamwork between providers, administrators, coders, billing staff, and IT personnel.

7. QUESTION:

When the scope does not get to the cecum, should we still bill a colonoscopy and do we need a modifier? What is the difference between modifier 52 and modifier 53?

Answer: As per 2016 CPT, when performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation. If unable to get beyond the splenic flexure, only the sigmoidoscopy series can be billed.

In the course of a colonoscopy which is other than diagnostic or screening, if the cecum or colon-small intestine anastomosis is not reached but the scope is passed beyond the splenic flexure, report the procedure with 52 modifier.

According to the American Medical Association (AMA) 2017 CPT Professional guidance book, "a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities."

52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

53 Discontinued Procedure: Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Example 1: Colonoscopy performed for evaluation of iron deficiency anemia. The scope was passed beyond the splenic flexure, but not to the cecum or colon-small intestine anastomosis, because of inadequate prep. The physician indicates that the patient will be brought back for repeat procedure after re-prep tomorrow. Since the exam was incomplete for unforeseen circumstances, and was a diagnostic (not therapeutic) procedure, the patient is returning for complete colonoscopy and modifier 53 should be added to 45378.

Example 2: A 65-year-old female, asymptomatic, is undergoing colonoscopy for abnormal CT of GI tract. The scope was advanced to the rectosigmoid area, but prep is incomplete and visibility was not acceptable, thus the procedure could not be completed. The patient is returning for re-evaluation after repeat prep. Since the scope did not get beyond the splenic flexure, only sigmoidoscopy can be reported.

If a therapeutic colonoscopy (44389-44407, 45379, 45380, 45381, 45382, 45384, 45388, 45398) is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.

Example 3: A 54-year-old is undergoing screening colonoscopy. An obstructing mass found in the transverse colon, which prevented examination of the right colon. Biopsies were taken. Modifier 52 and either modifier PT (if a Medicare beneficiary) or 33 (if a commercial, Medicaid, Tricare patient) would be added to 45380. This indicates the procedure was intended to be screening; but once a biopsy was performed it became therapeutic, and because it was incomplete, modifier 52 is reported.

8. QUESTION:

We are getting requests for refunds of previously paid claims by payors who had outside agencies audit their records. These audits usually involves 45385 and 45380-59. The documentation that we sent supports billing for both techniques. We always look at every endoscopy report before we submit claims and only use the 59 modifier if the biopsy is done to a separate lesion from the one that was snared. What can we do?

Answer: This is a common scenario with practices in the United States. This usually involves the commercial payors and some Medicare replacement plans. You will need to appeal and submit documentation to support your billing. Before doing so, ask your administrator to check the payor contract to make sure that there are no clauses that stipulate that the payor will only pay for one technique. You will need to submit a copy of the endoscopy report which shows separate lesions and separate techniques, CCI (correct coding initiative) policy chapter six, section H, #23 which states that as long as there are separate lesions addressed both are payable. Also submit a copy of a claim scrubber which shows that both are payable with a 59 modifier.

9. QUESTION:

Our doctors see patients in the office prior to a screening colonoscopy. The doctors take a complete history, do a review of systems (ROS) and a thorough exam. If the only diagnosis is "screening for colon cancer," can we still bill an office visit?

Answer: Since December 27, 2015, the Department of Labor has mandated that commercial plans that are non-grandfathered (i.e., plan that conforms to the ACA guidelines) are required to pay for the visit prior to screening with no cost sharing by the patient. This is not a consultation since there is no request for a consult, but just a transfer of care since the request (by patient or by referral source) is for a preventive procedure to be done. The diagnosis code for screening or family history of polyps or cancer is covered at 100% and would be the primary diagnosis. If the patient has a complaint or abnormality, this would not be screening and would be subject to plan benefits. The codes to use would be S0285 since July 1, 2016, or 99201-99215. It is up to each practice to query the most common payors to find out policy, to verify the codes to be used and also to check eligibility upon patient scheduling/appointments.

For Medicare, Medicaid and those patients who participate in a grandfathered plan (those plans that do not conform to the ACA (Affordable Care Act), an E/M visit prior to the colonoscopy is not covered and will be denied with no patient responsibility, unless the patient has symptoms or a chronic condition/disease that has to be managed by the GI provider. If you inform the patient ahead of time that this visit is non-covered and they wish to pay for it out-of-pocket, that is the patient's choice. An advance beneficiary notice (ABN) is not required, but it is sensible to obtain a waiver of some type. If the patient insists that the visit is billed to Medicare, use an unlisted E/M code or preventive service code (99401-99404 series) with GY modifier, which tells the carrier it is a non-covered service and the denial shifts to patient responsibility.

10. QUESTION:

When our doctor uses a clip to close a gastrocutaneous fistula, what CPT code do we use? I am told we are supposed to use 43870 for closure of gastrostomy.

Answer: There is no CPT code for endoscopic closure of gastrostomy, therefore, only code 43999, (Unlisted procedure of stomach) can be billed. Make sure to use the comment field (Box 19) and enter "endoscopic closure" when submitting the claim. If you don't enter the description of the procedure that was unlisted, Medicare will return the claim as unprocessable. Even with commercial payors, it would be a good idea to enter the detail in the comment field. Use of 43870 is incorrect since this applies to an open closure of gastrostomy.