2015 CPT®

CØD1NG UPDATES

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2015 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.

The society advisors would like to thank Kathleen Mueller for her contribution to the development of the "Frequently Asked Questions" for the coding update.

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There are significant changes to coding for lower GI endoscopic procedures in CPT 2015. These changes follow similar revisions to the upper GI endoscopy codes in CPT 2014 and mark the conclusion of a multiple-year effort to update the terminology of the GI endoscopy codes.

General Concepts for all GI Endoscopy Procedures

In recent years, the CPT Editorial Panel has been replacing the terminology "with or without" in codes throughout the CPT book with "including, when performed" in an effort to standardize the language and make the code descriptors more accurate. Previously, all GI endoscopy family base codes contained the language *"diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)."* In CPT 2014 "with or without" was replaced by "including, when performed" for esophagoscopy, EGD and ERCP. The same terminology reconciliation will be made to ileoscopy, pouchoscopy, flexible sigmoidoscopy, colonoscopy through stoma and colonoscopy in CPT 2015. This represents an editorial change and does not change the way the codes are reported.

The CPT Editorial Panel has also been replacing "bowel" with "intestine" throughout the CPT book. This represents an editorial change and does not change the way the codes are reported.

Placement of stent

Existing lower GI endoscopy codes for placement of endoscopic stents include predilation. The new lower GI endoscopy codes for placement of endoscopic stents now include pre-dilation, post-dilation and guide wire passage, when performed, consistent with the changes made to stent placement codes for upper GI endoscopy procedures. Placement of stent should be reported without a reduced services modifier 52, even if all three components (pre-dilation, post-dilation, guide wire passage) are not performed during the same session. Separate reporting of pre-dilation, post-dilation or guide wire passage is not appropriate, as these services are now bundled into the code for the placement of the stent.

Control of Bleeding

Previous code descriptors for control of bleeding codes included a list of examples such as injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler and plasma coagulator. The new descriptor for control of bleeding replaces all examples with "any method" throughout all GI endoscopy families. Do not report submucosal injection if the injection was part of the control of bleeding procedure. New language in the section guidelines clarifies that when bleeding occurs as the result of an endoscopic procedure, control of bleeding is not separately reported during the same operative session.

Ablation

New codes for ablation procedures now include pre- and post-dilation and guide wire passage, when performed. Separate reporting of pre- or post-dilation or guide wire passage is no longer appropriate, as these services are bundled into the code for ablation. Ablation procedures are not reported with a reduced services modifier 52 when all three components (pre-dilation, post-dilation or guide wire passage) are not performed during the same session. Separate reporting of pre-dilation, post-dilation or guide wire passage is not appropriate, as these services are now bundled into the code for the ablation.

Endoscopic Mucosal Resection

Endoscopic mucosal resection (EMR) can include injection-assisted, cap-assisted and ligation-assisted techniques. All techniques involve 1) Identification and demarcation of the lesion; 2) Submucosal injection to lift the lesion; and 3) Endoscopic snare resection. Separate reporting of submucosal injection, banding or snare polypectomy is not appropriate, as these services are bundled into the code for EMR. When biopsy is performed on the same lesion as EMR, biopsy is not reported.

Colonoscopy

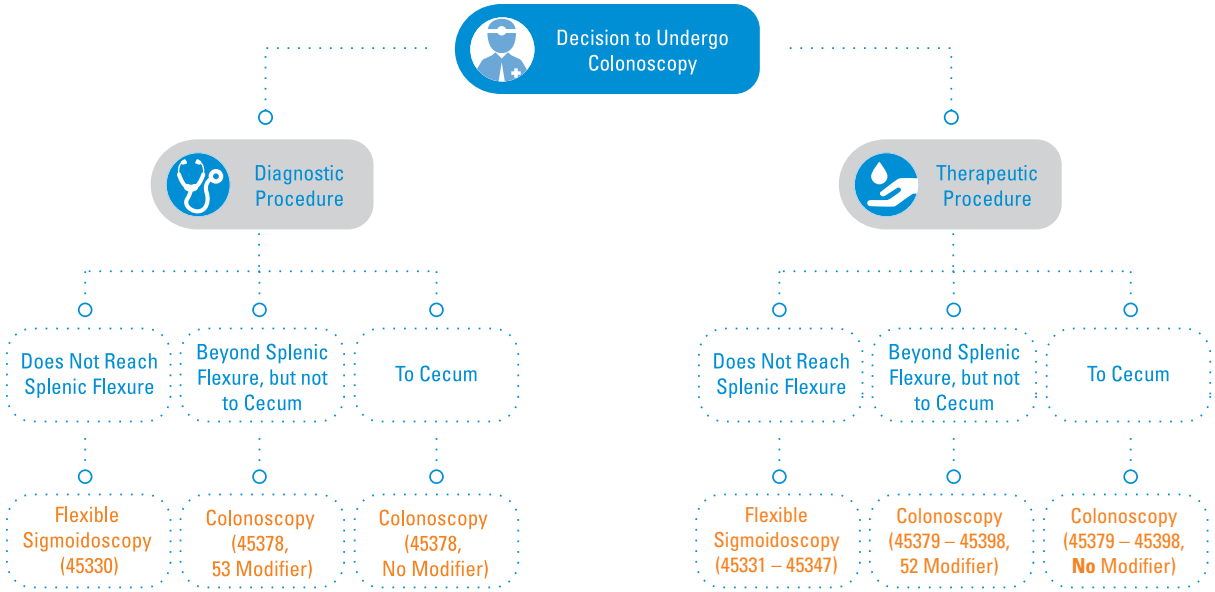
The definition of a colonoscopy examination is now specifically described in CPT as the examination of the entire colon, from the rectum to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis.

- When performing a diagnostic or screening 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 a therapeutic examination colonoscopy 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.

New codes for the colonoscopy family include endoscopic mucosal resection (EMR), band ligation and decompression for pathologic distention. Revised codes address appropriate reporting of ablation and stent placement.

Important Correction

Page 284 of the 2015 CPT Professional Guide has an error in the bottom right box of the Colonoscopy Decision Tree. **Below is the correct version of the Decision Tree.** When coding a therapeutic procedure to the cecum, bill the appropriate colonoscopy CPT code with **NO modifier.** Please see **https://download.ama-assn.org/resources/doc/cpt/x-pub/cpt-corrections-errata-2015.pdf** for further information. Please note that the "Diagnostic Procedure" decision node can include screening or diagnostic procedures.



Medicare Payment for Colonoscopy Procedures

In the Medicare Physician Fee Schedule (MPFS) final rule for 2015, CMS finalized a new, more transparent rate-setting process. CMS will propose values for the vast majority of new, revised and potentially misvalued codes and consider public comments before establishing final values for the codes. CY 2015 will be a transition year, when updates to the colonoscopy and other lower GI endoscopy codes will be included in the CY 2016 proposed rule.

Beginning with rulemaking for CY 2017, CMS will publish the proposed values for the following calendar year during June–July, providing interested parties the opportunity to submit comments before the values are finalized. This will require CMS to address comments when the final rule is published in November.

Use of Temporary G-codes for Lower GI Endoscopy for Medicare

To implement this new initiative on transparency, CMS finalized the use of temporary G-codes to facilitate continued payment for new or modified CPT codes that do not have the benefit, due to the timing of the AMA RUC process, of first being published in the proposed rule.

Since the lower GI endoscopy CPT code set is changing for CY 2015, including the deletion of some of the CY 2014 codes, CMS is creating G-codes for 10 lower GI endoscopy services to allow practitioners to report services provided to Medicare beneficiaries in CY 2015 the same way they did in CY 2014.

For existing procedures that have new CPT code assignments in CPT 2015, CMS requires physicians to report the G-code instead of the corresponding 2015 CPT code.

Crosswalking Certain CY 2014 Lower GI Endoscopy CPT Codes to 2015 HCPCS G-Codes for Medicare During CY 2015

CY 2014 CPT Code	CY 2015 HCPCS Code	Long Descriptor
44383	G6018	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)
44393	G6019	Colonoscopy through stoma; with ablation of tumor(s), polyp(s) or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
44397	G6020	Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)
44799	G6021	Unlisted procedure, intestine

CY 2014 CPT Code	CY 2015 HCPCS Code	Long Descriptor
45339	G6022	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45345	G6023	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45383	G6024	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45387	G6025	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
0226T	G6027	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed
0227T	G6028	Anoscopy, high resolution (HRA) (with magnification and chemica

New CPT Codes Not Recognized in CY 2015 by Medicare

In the final rule, CMS set the value of all other new lower GI endoscopy CPT codes at 0.00 RVUs. CMS has provided guidance as to how physicians should report new endoscopic procedures that CMS has assigned 0.00 RVUs. CMS's intent is for physicians to bill these endoscopic services as they would have in CY 2014. Therefore, for Medicare beneficiaries, new procedures that do not have G-code crosswalks should continue to be reported as they were in 2014, noting that code G6021 should be used for unlisted procedure, intestine.

CPT 2015 Code	Description	CMS CY 2015 Crosswalk
44381	Small bowel endoscopy w/dilation	44380, G6021
44403	Colonoscopy through stoma w/EMR	44388, G6021
44404	C-stoma w/submucosal injection	44388, G6021
44405	C-stoma w/dilation	44388, G6021
44406	C-stoma w/ultrasound	44388, G6021

CPT 2015 Code	Description	CMS CY 2015 Crosswalk
44407	C-stoma w/US-guided FNA	44388, G6021
44408	C-stoma w/decompression	44388, G6021
45349	Flexible sigmoidoscopy w/EMR	45330, G6021
45350	Flexible sigmoidoscopy w/band ligation (e.g. hemorrhoids)	45330, G6021
45390	Colonoscopy w/EMR	45378, G6021
45393	Colonoscopy w/decompression	45378, G6021
45398	Colonoscopy w/band ligation (e.g. hemorrhoids)	45378, G6021

When to report CPT and HCPCS G-codes for physician services provided to Medicare (fee-for-service, Medicare Advantage) patients in 2015?

- If the code has not changed from 2014 to 2015:
  - Report the CPT code.
  - CMS fees are based on 2014 values.
- If the code has changed from 2014 to 2015:
  - Report the G code.
  - CMS fees are based on 2014 values.
- If the code is new for 2015:
  - Report the CY 2014 CPT code(s) and/or G6021, as appropriate.
  - Do not report the CPT 2015 codes, as they are not valued by CMS during CY 2015.

Physicians are encouraged to reach out to payors regarding guidance on how to report the new 2015 CPT codes for non-Medicare (e.g. commercial, HMO, PPO, Medicaid, Tricare, etc.) lines of service.

Which CPT and HCPCS G-codes should the ASC or HOPD use when submitting a claim for facility services provided to Medicare beneficiaries in 2015?

- The facility should report the new CPT codes for 2015.
- The facility should not report HCPCS codes G6018-G6028.
- The facility should continue to report HCPCS codes G0104, G0105 and G0121, as appropriate.

Proposing Values for New CPT Codes to Non-Medicare Payors

Many payors have not announced whether they will recognize the new CPT codes and, if so, what the value of the codes should be. When beginning a dialogue with payors, it may be helpful for physicians to look at the values for the base codes and the value of the increment. The increment (from the upper GI endoscopy codes) could be added to a lower GI endoscopy base code to propose a reimbursement rate or calculate an RVU for the new lower GI endoscopy codes.

The physician work increments (from the 2015 Final Rule) for upper GI endoscopy procedures are as follows. Note that this does not account for practice expense and malpractice liability differences between the base code and increment procedure.

Procedure	wRVU Increment Over Base Code
Submucosal injection	0.30
Balloon dilation	0.58
Endoscopic ultrasound (EUS)	1.38
Stent placement	1.98
Ablation	2.07
EUS with fine needle aspiration (FNA)	2.07
Endoscopic mucosal resection (EMR)	2.78

Colonoscopy Coding Updates

CPT Code	Short Description	Summary of Changes
	Guidelines	New definition. Colonoscopy is the examination of the entire colon, from the rectum to the cecum or colon-small intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. For screening or diagnostic colonoscopy, report 45378 with modifier 53 if unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances and provide appropriate documentation. For therapeutic examinations that do not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.
45399	Transabdominal colonoscopy via colotomy	Code 45355 has been deleted. Report with new code for unlisted colon procedure, 45399.
45378	Colonoscopy	Colonoscopy is the examination of the entire colon, from the rectum to the cecum or small-intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis.
45379	Foreign body(s) removal	"Foreign body(s)" replaces "foreign body."
45380	Biopsy	Not separately reportable with EMR code 45390 for the same lesion.
45381	Submucosal injection	Not separately reportable with EMR or control of bleeding described by 45382 and 45390 for the same lesion.
45382	Control of bleeding	"Any method" replaces previous examples. Not separately reportable with injection or banding of hemorrhoids described by 45381, 45398 for same lesion.
45384	Hot biopsy	Bipolar cautery was deleted as an example.
45385	Snare	Not separately reportable with endoscopic mucosal resection described by 45390 for the same lesion.
45386	Dilation	New language specifies use of transendoscopic balloon. Dilation of multiple strictures can be reported with the 59 modifier for each additional stricture dilated. Not separately reportable with ablation or stent placement described by 45388, 45389. Use 74360 if fluoroscopic guidance is performed.

CPT Code	Short Description	Summary of Changes
45388	Ablation	Code 45383 has been deleted. New code 45388 includes balloon dilation, guide wire insertion and ablation. Not separately reportable with dilation code 45386 for the same lesion.
45389	Stent placement	Code 45387 has been deleted. New code 45389 includes pre- and post-dilation and guide wire passage. Not separately reportable with dilation code 45386. Use 74360 if fluoroscopic guidance is performed.
45391	Endoscopic ultrasound	Now specifies exam limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures. Report only once per session. Not separately reportable with EUS FNA code 45392 or radiologic ultrasound codes 76872, 76975.
45392	Endoscopic ultrasound with FNA	Now specifies exam limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures. Report only once per session. Not separately reportable with EUS code 45391 or radiologic ultrasound codes 76872, 76942, 76975.
45390	Endoscopic mucosal resection (EMR)	New code 45390 is not separately reportable with biopsy, submucosal injection, snare or band ligation described by 45380, 45381, 45385, 45398 for the same lesion.
45393	Decompression	New code 45393 for decompression for pathologic distention, such as volvulus or megacolon. Includes placement of decompression tube when performed. Report only once per session.
45398	Band ligation	New code 45398 is not separately reportable with control of bleeding code 45334 for the same lesion. Do not report in conjunction with EMR or hemorrhoidectomy described by 45390, 46221. Report control of active bleeding with band ligation with 45382.

Colonoscopy through Stoma

Colonoscopy through stoma has been specifically defined in CPT as the examination of the colon, from the colostomy stoma to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis. When performing a diagnostic or screening colonoscopy through stoma 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 44388 with modifier 53 and provide appropriate documentation. If a therapeutic colonoscopy is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy through stoma code with modifier 52 and provide appropriate documentation.

New codes for the colonoscopy through stoma family include endoscopic mucosal resection, submucosal injection, balloon dilation, EUS, EUS with FNA, and decompression for pathologic distention. Revised codes address appropriate reporting of ablation and stent placement.

CPT Code	Short Description	Summary of Changes
	Guidelines	New definition. Colonoscopy through stoma is now defined as the examination of the colon, from the colostomy stoma to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis. When performing a diagnostic or screening colonoscopy through stoma 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 44388 with modifier 53 and provide appropriate documentation. If therapeutic colonoscopy is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy through stoma code with modifier 52 and provide appropriate documentation.
44388	Colonoscopy through stoma	Colonoscopy through stoma is the examination of the remaining colon to the cecum or colon-small intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. When performing a diagnostic or screening exam, report 44388 with modifier 53 if unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances and provide appropriate documentation.
44389	Biopsy	Not separately reportable with EMR code 44403 for the same lesion.
44390	Foreign body(s) removal	"Foreign body(s)" replaces "foreign body."

CPT Code	Short Description	Summary of Changes
44391	Control of bleeding	"Any method" replaces previous examples. Not separately reportable with injection described by 44404 for same lesion.
44392	Hot biopsy	Bipolar cautery was deleted as an example.
44401	Ablation	Code 44393 has been deleted. New code 44401 includes balloon dilation, guide wire insertion and ablation. Not separately reportable with dilation code 44405 for the same lesion.
44394	Snare	Not separately reportable with endoscopic mucosal resection described by 44403 for the same lesion.
44402	Stent placement	Code 44397 has been deleted. New code 44402 includes pre- and post-dilation and guide wire passage. Not separately reportable with dilation code 44405. Use 74360 if fluoroscopic guidance is performed.
44403	Endoscopic mucosal resection (EMR)	New code 44403 is not separately reportable with biopsy, submucosal injection or snare described by 44389, 44394, 44404 for the same lesion.
44404	Submucosal injection	New code 44404 is not separately reportable with endoscopic mucosal resection or control of bleeding described by 44391, 44403 for the same lesion.
44405	Balloon dilation	New code 44405 for transendoscopic balloon dilation. Dilation of multiple strictures can be reported with the 59 modifier for each additional stricture dilated. Not separately reportable with ablation or stent placement described by 44401, 44402. Use 74360 if fluoroscopic guidance is performed.
44406	Endoscopic ultrasound	New code 44406 is not separately reportable with EUS FNA code 44407 or radiologic ultrasound code 76975. Report only once per session.
44407	Endoscopic ultrasound (EUS) with FNA	New code 44407 is not separately reportable with EUS code 44406 or radiologic ultrasound codes 76942 and 76975. Report only once per session.
44408	Decompression	New code 44408 for decompression for pathologic distention, such as volvulus or megacolon. Includes placement of decompression tube when performed. Report only once per session.

Enteroscopy

A new definition and instructions for reporting antegrade transoral small intestine endoscopy (i.e., enteroscopy) have been added to the section guidelines. Enteroscopy is defined by the most distal segment of small intestine that is examined; coding does not reflect the technology used to perform the examination.

Codes in the 44360 family for enteroscopy, not including ileum (44360–44373), are endoscopic procedures to visualize the esophagus through the jejunum using an antegrade approach. Codes in the 44376 family for enteroscopy, including ileum (44376–44379), are endoscopic procedures to visualize the esophagus through the ileum using an antegrade approach.

If an endoscope cannot be advanced at least 50 cm beyond the pylorus, see the appropriate code in the EGD family (43233, 43235–43259, 43266, 43270). If an endoscope can be passed at least 50 cm beyond pylorus, but only into jejunum, see the appropriate code in the enteroscopy, not including ileum family (44360–44373).

To report retrograde examination of small intestine via anus or colon stoma, use 44799, Unlisted procedure, small intestine.

There were no changes to the language of the individual CPT codes.

Ileoscopy

New codes have been added to the ileoscopy family for transendoscopic balloon dilation and stent placement.

CPT Code	Short Description	Summary of Changes
44380	Ileoscopy	Editorial: "Including collection of specimen(s) by brushing or washing, when performed" replaces "with or without collection of specimen(s)."
44382	Biopsy	No change
44381	Balloon dilation	Report new code 44381 with modifier 59 for each additional stricture dilated. Not separately reportable with stent placement code 44384 for the same lesion. Use 74360 if fluoroscopic guidance is performed.
44384	Stent placement	Code 44383 has been deleted. New code 44384 includes pre- and post-dilation and guide wire passage. Not separately reportable with dilation code 44381. Use 74360 if fluoroscopic guidance is performed.

Pouchoscopy

New section guidelines will instruct users to report pouch endoscopy codes for endoscopic examination of a patient who has undergone resection of colon with ileo-anal anastomosis (e.g., J pouch). Language changes to the pouchoscopy base and biopsy codes are editorial in nature.

CPT Code	Short Description	Summary of Changes
44385	Pouchoscopy	Editorial: Terminology updated to include Kock pouch and ileal reservoir [S or J] as examples. "Including collection of specimen(s) by brushing or washing, when performed" replaces "with or without collection of specimen(s)."
44386	Biopsy	No change

Flexible Sigmoidoscopy

Specific instructions for reporting flexible sigmoidoscopy have been added to the section guidelines. Report flexible sigmoidoscopy for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure. Report flexible sigmoidoscopy for endoscopic examination of a patient who has undergone resection of the colon proximal to the sigmoid (e.g., subtotal colectomy) and has an ileo-sigmoid or ileo-rectal anastomosis. New codes for the flexible sigmoidoscopy family include endoscopic mucosal resection and band ligation. Revised codes address appropriate reporting of ablation and stent placement.

CPT Code	Short Description	Summary of Changes
45330	Flexible sigmoidoscopy	Editorial: "Including collection of specimen(s) by brushing or washing, when performed" replaces "with or without collection of specimen(s)."
45331	Biopsy	Not separately reportable with EMR code 45349 for the same lesion.
45332	Foreign body(s) removal	"Foreign body(s)" replaces "foreign body."
45333	Hot biopsy	Bipolar cautery was deleted as an example.
45334	Control of bleeding	"Any method" replaces previous examples. Not separately reportable with injection or banding of hemorrhoids described by 45335, 45350 for same lesion.

CPT Code	Short Description	Summary of Changes
45335	Submucosal injection	Not separately reportable with control of bleeding or endoscopic mucosal resection described by 45334, 45349 for the same lesion.
45337	Decompression	New language clarifies decompression for pathologic distention, such as volvulus or megacolon. Includes placement of decompression tube when performed. Report only once per session.
45338	Snare	Not separately reportable with endoscopic mucosal resection described by 45349 for the same lesion.
45346	Ablation	Code 45339 has been deleted. New code 45346 includes balloon dilation, guide wire insertion and ablation. Not separately reportable with dilation code 45340 for the same lesion.
45340	Dilation	New language specifies use of transendoscopic balloon. Dilation of multiple strictures can be reported with the 59 modifier for each additional stricture dilated. Not separately reportable with ablation or stent placement described by 45346, 45347. Use 74360 if fluoroscopic guidance is performed.
45341	Endoscopic ultrasound	Not separately reportable with EUS FNA code 45342 or radiologic ultrasound codes 76872, 76975. Report only once per session.
45342	Endoscopic ultrasound (EUS) with FNA	Not separately reportable with EUS code 45341 or radiologic ultrasound codes 76872, 76942, 76975. Report only once per session.
45347	Stent placement	Code 45345 has been deleted. New code 45347 includes pre- and post-dilation and guide wire passage. Not separately reportable with dilation code 45340. Use 74360 if fluoroscopic guidance is performed.
45349	Endoscopic mucosal resection (EMR)	New code 45349 is not separately reportable with biopsy, submucosal injection, snare or band ligation described by 45331, 45335, 45338, 45350 for the same lesion.
45350	Band ligation	New code 45350 is not separately reportable with control of bleeding code 45334 for the same lesion. Do not report in conjunction with EMR or hemorrhoidectomy described by 45349, 46221. Report control of active bleeding with 45334. Report only once per session.

Unlisted Procedures

A new code has been developed and one revised to distinguish unlisted procedure of the colon from unlisted procedure of the small intestine and unlisted procedure of the rectum.

CPT Code	Short Description	Summary of Changes
44799	Unlisted procedure, small intestine	Specifies unlisted procedure of small intestine.
45399	Unlisted procedure, colon	New code for unlisted procedures of the colon. Note: the CPT Errata indicates code 45399 does not include moderate sedation. The moderate sedation bullseye symbol for code 45399 was placed in the CPT 2015 book in error. See the "important correction" on page four for more information.

Other Changes

Category I Codes

HIGH RESOLUTION ANOSCOPY

- **Category III codes 0226T and 0227T** were deleted and replaced with two **new Category I codes** for high-resolution anoscopy (HRA). Code **46601** describes a diagnostic HRA with collection of specimens by brushing or washing, when performed. Code **46607** describes HRA with single or multiple biopsies. Both codes include chemical agent enhancement and operating microscope or colposcope, if used. Code 69990 cannot be reported in conjunction with these codes.

LIVER ELASTOGRAPHY

- **New code 91200** was added for liver elastography performed via mechanically-induced shear wave technique, such as vibration. The code includes interpretation and report, but not imaging. The code describes liver fibrosis evaluation, such as Fibroscan®, Philips® shear wave ultrasound elastography and other hepatic shear wave technologies. If performing ultrasound with liver elastography, report using 76700, Ultrasound, abdominal, real time imaging documentation, complete, OR 76705, Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow up), AND 0346T, Ultrasound, elastography (list separately in addition to code for primary procedure).

Care Management Services

The Complex Chronic Care Coordination Services section has been renamed Care Management Services. The guidelines section was completely revised with the addition of two new subsections, Chronic Care Management Services and Complex Chronic Care Management Services, and the deletion of 99488 for face-to-face visits. Code 99488 describing chronic care management with face-to-face visits has been deleted in 2015 because face-to-face visits are no longer a requirement of care management services. To report one or more face-to-face visits, use the appropriate evaluation and management (E/M) code.

The new Chronic Care Management Services subsection includes guidelines for new code 99490 clarifying that this code is reported for patients receiving at least 20 minutes of chronic care management per calendar month. Service of less than 20 minutes per calendar month is not reported separately.

The new Complex Chronic Care Management Services subsection includes guidelines for revised codes 99478 and 99489 that describe at least 60 minutes of complex chronic care management services. It includes information on identification of patients receiving complex care and examples of typical patients. Service of less than 60 minutes per calendar month is not reported separately. Add-on code 99498 cannot be reported for less than 30 minutes of service in addition to the initial 60 minutes during a calendar month.

Category II Codes

- **Category II** codes are a set of supplemental tracking codes for performance measurement. The codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care. The use of Category II codes is optional. They are not required for correct coding and may not be used as a substitute for Category I codes. Category II codes are released on a semi-annual basis in January and July and are published on the AMA's website.
- **Codes 3775F and 3776F** were added to report detection of adenomas or other neoplasms during colonoscopy screening. Report code 3775F for detection of adenomas or other neoplasms during screening colonoscopy. Report code 3776F if no adenoma or neoplasm is found during screening colonoscopy. The codes are used with the new Screening Colonoscopy Adenoma Rate Detection measure listing within the new Screening Colonoscopy Adenoma Detection Rate (SCADR) measure set. This measure is used to determine whether or not the patient age 50 or older has had at least one adenoma or other colorectal cancer precursor detection during a screening colonoscopy.

Medical exclusions exist for not having at least one adenoma or other colorectal cancer precursor detected. Therefore, the reporting instructions direct use of the 1P modifier in conjunction with code 3776F to identify the exclusion circumstance.

Category III Codes

Category III codes are a temporary set of codes for emerging technologies, services and procedures. The codes "sunset," or are retired, from the CPT book after five years, if they are not accepted as Category I codes. They typically replace unlisted codes that were previously used for new procedures or services. If a Category III code describes the procedure or service performed, it must be reported. An unlisted code or less specific Category I cannot be reported in place of an active Category III code. Category III codes are released on a semi-annual basis in January and July and are published on the AMA's website.

- **Codes 0226T [high resolution anoscopy (HRA)] and 0227T (HRA with biopsy)** have been deleted and replaced by Category I codes 46601 and 46607.
- **New code 0355T,** Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report, was added effective July 1, 2014, for capsule endoscopy of the colon. Do not report 0355T in conjunction with codes 91110 or 91111.
- **New code 0377T,** Anoscopy with directed submucosal injection of bulking agent for fecal incontinence, was added effective Jan. 1, 2015, for anoscopy with injection of bulking agent for fecal incontinence, using products such as NASHA/Dx (Solesta®). As with all other anoscopy services, this code is reported only once per session.

Do not report this service with code 46600, anoscopy.

G-Codes

CMS has established HCPCS code G0464 for colorectal cancer screening via stool-based DNA and fecal occult hemoglobin tests, such as Cologuard™.

- **G0464** Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)
  NOTE: Do not bill this code with codes 82270, 82274, G0328.

Frequently Asked Coding Questions

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QUESTION: One of the most confusing aspects of gastroenterology billing is submitting claims for screening colonoscopy. Can you explain the differences between average risk and high risk screening?

ANSWER: Commercial payors may decide to follow Medicare policy on colorectal cancer (CRC) screening or use their own definitions on coverage policies and benefits, which can make billing screening colonoscopies more difficult. Listed below are the definitions of average and high risk, and some associated billing tips.

Average risk screening: Lack of symptoms and abnormalities

- Screening, by definition, is a service performed on a patient in the absence of signs and symptoms.
- Medicare's definition of average risk is no personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease, including Crohn's disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.
- For most payors, a patient is eligible for screening colonoscopy on or after age 50. Some payors allow for screening to begin at age 45 for patients of certain gender and/or ethnic origin. If there are questions, check the summary of plan documents (SPD) and/or the plan's coverage policies.
- Since Jan. 1, 2011, Medicare waives the co-pay and deductible for the professional and facility fees for screening colonoscopy at 100 percent with no patient financial responsibility.
- In the final rule for 2015, Medicare expanded the waiver of co-pay and deductible to include anesthesia for screening colonoscopy. A -33 modifier should be added to the 00810 anesthesia code to indicate the circumstance was preventive. This coverage "trumps" local contractor medical necessity policies now in existence in a screening circumstance. In the circumstance when a screening procedure becomes therapeutic (see next bullet), the PT modifier should be applied to the anesthesia service. A copay will still apply, but the deductible should be waived.
- If the screening colonoscopy is negative, a follow-up procedure is allowed every 10 years by Medicare. The frequency for follow-up for commercial payors is dependent upon the patient coverage/plan, but most follow either CMS policy or the U.S. Multi-Specialty Task Force (MSTF) recommendations.
- Billing for a screening colonoscopy in an average risk patient:
  - Medicare: G0121
  - Commercial, Medicaid, exchange/marketplace, Tricare: 45378 with the appropriate ICD-9 (through Sept. 30,

2015) or ICD-10 code (effective Oct. 1, 2015) for screening:

- ICD-9 codes for colorectal cancer screening: V16.0, V18.51, V18.59, V70.0, V76.41, V76.50, V76.51
- ICD-10 codes for colorectal cancer screening: Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79

What happens when a lesion is found during a screening colonoscopy?

- During a screening colonoscopy, polyps or other lesions can be found which are biopsied or removed. The procedure is now considered a "surgical colonoscopy," often increasing the patient's financial responsibility, even though the intent was screening.
  - For commercial payors, add modifier 33 to the surgical claim, which informs the payor that the intent of the colonoscopy was a preventive service. If billed with screening as the principal diagnosis and the finding as the secondary diagnosis, many commercial payors will continue to pay preventive benefits.
  - For Medicare, add modifier PT to the surgical claim, which informs Medicare that the intent of the colonoscopy was a preventive service. Modifier PT waives the patient's deductible, but the patient is now responsible for the 20 percent co-pay.
    - Effective Jan. 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a colorectal cancer screening test should include the 33 modifier on the claim line with the anesthesia service.
    - In situations that begin as a colorectal cancer screening test, but for which another service, such as colonoscopy with polyp removal, is actually furnished, the anesthesia professional should report a PT modifier on the claim line rather than the 33 modifier. The patient is now responsible for the 20 percent co-pay for the anesthesia service.

High risk screening/surveillance: Patients who have a personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease, or a family history of adenomatous polyps, colorectal cancer, familial adenomatous polyposis or hereditary nonpolyposis colorectal cancer.

- Medicare defines family history as including only first degree relatives (siblings, parents or children)
- Commercial payors may define family history to also include two or more second degree relatives. If there are questions, check the patient's SPD and/or the plan's coverage policies.
- Hyperplastic polyps do not meet the definition of adenomatous polyps; patients who only have hyperplastic polyps are considered to be average risk if there are no other high-risk factors, as described above.
- For high-risk patients, repeat screening is covered by Medicare after a minimum of two years and covered at 100 percent.
- Billing for screening/surveillance colonoscopy in a high risk patient:
  - Medicare: G0105
  - Commercial, exchange, Medicaid, Tricare: 45378
- Many payors have screening policies, which indicate that once the patient has a condition that requires surveillance at intervals of less than 10 years, the patient is no longer eligible for preventive benefits.
  - This causes much misunderstanding by patients.
  - Eligibility needs to be verified on all patients prior to scheduling.

- After eligibility is verified, a thorough explanation of the patient's benefits and financial responsibility should be given to the patient in order for the patient to make an informed decision.

What is a diagnostic colonoscopy?

A diagnostic colonoscopy is a procedure performed for the evaluation of a patient who presents with symptoms and/or abnormalities prompting evaluation of the lower GI tract.

- No age limits.
- Follows standard insurance benefits.
- Payors may use external criteria for determining coverage (medical necessity) such as MCG, InterQual or the 2012 ASGE Appropriate Use of Gastrointestinal Endoscopy Guideline.

CAUTION: If a patient undergoes a CRC screening test, such as a fecal occult blood test (FOBT), fecal immunochemical test (FIT) or Cologuard™, by another health-care professional and an abnormality (e.g. positive test) is found that prompts referral for a colonoscopy, the colonoscopy is no longer a screening procedure and for Medicare is no longer a preventive service.

- For Medicare, this means that the patient is now responsible for the co-pay and deductible for the diagnostic colonoscopy.
- For commercial payors, check the SPD and/or payor policy to see if a colonoscopy performed in an asymptomatic patient with a positive FIT or FOBT is still a preventive service (with waiver of financial responsibility) or not.

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

ANSWER: For Medicare, unless the patient has symptoms or a chronic condition/disease that has to be managed by the GI provider, an E/M visit prior to the colonoscopy is not covered and will be denied with no patient responsibility. 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 option. 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 with GY modifier, which tells carrier it is a noncovered service and the denial shifts to patient responsibility.

For private payors, it will depend whether preventive visits are covered. This is not a consultation since there is no request for a consult, but just a transfer of care since the request is for preventive procedure to be done. Remember that when billing new patient (99201–99205) or existing patient (99212–99215) E/M codes, there should be a chief complaint. Utilizing E/M visit codes with a screening diagnosis may not make sense to the payor since the patient undergoing screening should have no symptoms and this is considered a preventive visit, not a "sick" visit. Each payor may have individual policies; for instance, Anthem BC/BS policy is to bill this as a preventive visit 99381–99397. It is up to each practice to query the most common payors to find out policy and also to check eligibility upon patient scheduling/appointments.

QUESTION: Is there a difference regarding the use of modifiers 52 and 53 with regards to upper and lower endoscopic procedures?

ANSWER: Yes.

- EGD procedures: To report esophagogastroscopy where the duodenum is deliberately not examined (e.g., judged

clinically not pertinent) or because significant situations preclude such exam (e.g., significant gastric retention precludes safe exam of duodenum), append modifier 52, if repeat examination is not planned, or modifier 53, if repeat examination is planned.

- Example: EGD is performed and a tube is placed into the stomach. The duodenum is not examined and there is no plan to perform repeat EGD to examine the duodenum. Report procedure with modifier 52.
- Example: EGD is performed for evaluation of GI bleeding; the stomach is full of blood and the duodenum is not examined. Plan to control bleeding, lavage stomach and repeat upper endoscopy. Report procedure with modifier 53.

- Colonoscopy procedures:
  - 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 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.

QUESTION: Could you provide some examples of how to use and report modifiers 52 and 53 with regards to lower endoscopic procedures?

ANSWER: Yes.

Example: Colonoscopy done 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: 70-year-old male undergoing high risk screening due to personal history of transverse colon cancer. The scope was advanced to the ascending colon, but the prep was incomplete and the examination could not be completed. The physician plans to try again after repeat prep. Modifier 53 would be added to 45378 for the incomplete first attempt. If the second attempt is complete and no lesions are biopsied or removed, report G0105 for the subsequent procedure.

Example: 65-year-old female, asymptomatic, undergoing screening colonoscopy. The scope was advanced to the cecum, but prep is incomplete and visibility was not acceptable, thus adequate screening could not be completed. The patient is returning for re-evaluation after repeat prep. Modifier 53 would be added to 45378 for the incomplete first attempt. If the second attempt is complete and no lesions are biopsied or removed, report G0121 for the subsequent procedure.

Example: 54-year-old undergoing screening colonoscopy. 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 as it was incomplete, modifier 52 is reported.

QUESTION: What is the difference between "incident to" and split-shared billing as it applies to our mid-level providers?

ANSWER: This is a common question and also a major area of auditing concern, since this is closely investigated by the Office of Inspector General, RACs (recovery audit contractors) and individual payors. Make sure that all providers and billing staff are aware of the differences, which are listed below:

Incident to Services

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the patient's treatment room while these services are provided, but the physician must provide direct supervision. That is, the physician must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service. If the physician is in the ambulatory surgery center, even if it is adjacent to the office, that does not count as direct supervision

CMS MLN Matters SE0441 for "Incident to" Services

- "Incident to" services must be part of the patient's normal course of treatment.
- Once treatment has been adjusted by the nurse practitioner (NPP), or if a new problem is addressed during a follow-up encounter, "incident to" services are no longer met, and the service must be billed under the NPP who performed the service.
- "Incident to" services are not allowed in inpatient or nursing facility settings.
- Physician must be in the office suite and review the record to qualify for billing "incident to" — does not have to be the physician who initiated the patient's treatment.

  Example: 33-year-old female presents new to the GI practice for evaluation of atypical GERD symptoms. Dr. Brown completes a full history and physical, and then decides to prescribe a new regimen. He instructs the patient to return to clinic in one month.

  - This is a billable new clinic visit under Dr. Brown.

  Example: 33-year-old female with problems noted above returns to see the NPP for follow up. Patient reports that she feels better. NPP instructs the patient to continue with the same medication and return in three months for re-evaluation or sooner, if symptoms worsen. Physician in clinic reviews the NPP's documentation and agrees with treatment plan.

  - Billable follow-up clinic visit under physician — "incident to" services met.

  Example: 33-year-old female with problems noted above returns to see the NPP for follow up and symptoms have recurred, along with dysphagia. After the NPP examines the patient, the patient is scheduled for an EGD. Physician did not see the patient that day.

  - Billable visit under the NPP — "incident to" services not met; NPP changed course of treatment.

Split/shared Services

"A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer."

Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners

- Both the physician and the NPP must each personally perform part of the visit, and both the physician and the NPP must document the part(s) that he or she personally performed.
- Split/shared services are not billable in the skilled nursing facility/non-facility (SNF/NF) setting.
- Split/shared policy does not apply to critical care and procedures.

The following examples are unacceptable addendums by the physician:

- "I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM, and agree with the assessment and plan as written," signed by the physician.
- "Patient seen," signed by the physician.
- "Seen and examined," signed by the physician.
- "Seen and examined and agree with above (or agree with plan)," signed by the physician.
- "As above," signed by the physician.
- Documentation by the NPP stating, "The patient was seen and examined by myself and Dr. X., who agrees with the plan," with a co-sign of the note by Dr. X.
- No comment at all by the physician, or only a physician signature at the end of the note.

WPS Medicare, Part B, Inpatient Split/Shared Evaluation and Management (E/M) Services

Example: 55-year-old male seen as a follow up in the hospital for acute blood loss anemia and possible gastric ulcer. PA performs an interval history, detailed exam and moderate decision making.

Supervising physician's addendum:

"I personally examined the patient and agree with the assessment and plan noted above. Patient notes tenderness in the LUQ and positive bowel sounds. His hemoglobin is still low following two units of blood. I'm concerned about ongoing blood loss and abdominal tenderness. I would like to get the first available EGD to look for source of bleeding and pain."

- Billable visit under the supervising physician — split/shared criteria met.