

2016 CPT[®] CODING UPDATES

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2016 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.

Table of Contents

Coding Updates.....	4
Other Changes and Clarifications.....	4
Colonoscopy.....	6
Frequently Asked Questions.....	8

Beginning January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) will accept claims using the 2016 Category I CPT codes for lower GI endoscopy procedures.

Coding Updates

Category I Code

ESOPHAGOGASTRIC FUNDOPLASTY

Code 43210 — A new code has been established in the *Esophagogastroduodenoscopy* section to describe a transoral approach to a surgical esophagogastric fundoplasty procedure. Code 43210, *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed*, is for a partial or complete esophagogastric fundoplasty and includes duodenoscopy when performed.

An exclusionary parenthetical note has been added to restrict the use of this code with esophagoscopy and EGD services 43180, 43191, 43197, 43200 and 43235.

Other Changes and Clarifications

Category I Codes

LIVER ELASTOGRAPHY

Code 91200, *Liver elastography, mechanically induced shear wave (e.g., vibration), without imaging, with interpretation and report*, was added in 2015 to report liver elastography performed via mechanically-induced shear wave technique, such as vibration. The code, which describes liver fibrosis evaluation, includes interpretation and report, but not imaging. CMS has clarified that should an evaluation and management service be performed on the same day, it is separately reportable.

ESOPHAGEAL BALLOON DISTENSION STUDY

Code 91040, *Esophageal balloon distension study, diagnostic, with provocation when performed*, was revised for 2016 to clarify this as a diagnostic procedure. Code 91040 does not require the performance of provocation to report this procedure. While esophageal distension is measured in all patients who undergo esophageal balloon distension, not all patients undergo provocation during the performance of the study.

CARE MANAGEMENT SERVICES

In 2015, CPT renamed the Complex Chronic Care Coordination Services section Care Management Services. The guidelines section was completely revised and added two new subsections, Chronic Care Management Services and Complex Chronic Care Management Services.

The Chronic Care Management Services subsection includes guidelines for 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 Complex Chronic Care Management Services subsection includes guidelines for revised codes 99487 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 99489 cannot be reported for less than 30 minutes of service in addition to the initial 60 minutes during a calendar month reported with code 99497.

ADVANCE CARE PLANNING

Codes 99497 and 99498 are used to report the face-to-face service between a physician or other qualified health-care professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. Code 99497 is used to report the first 30 minutes of advance care planning. Add-on code 99498 is used to report each additional 30 minutes.

Category III Codes

Category III codes are a temporary set of codes for emerging technologies, services and procedures. These 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 code 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.

New Category III Codes

Codes 0392T, *Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band)*, and **0393T**, *Removal of esophageal sphincter augmentation device*, have been established to report insertion and removal of a magnetic band placed externally on the esophageal sphincter. These codes should be used for reporting the surgical placement and removal of esophageal sphincter augmentation devices for the treatment of conditions such as gastroesophageal reflux disease (GERD). There is an exclusionary parenthetical note to not report 0393T with other laparoscopic fundoplasty procedures as described in codes 43279, 43280, 43281 and 43282.

Code +0397T, *Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)*, is an add-on code to report optical endomicroscopy (OE) services when performed with an ERCP procedure to assist in the diagnosis of biliary strictures and the presence of biliary cancer. Report code 0397T in addition to the code for the ERCP procedure; do not report 0397T in conjunction with code 88375.

Code 0405T, *Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time*, has been established to report oversight of the care of an extracorporeal liver assist system patient, and is used to track enrollment of patients into a liver assist system clinical trial to capture physician work related to oversight of the patient’s care. Services reported with 0405T are separate from critical care and other evaluation and management services.

Deleted Category III Codes

Effective January 1, 2016, codes **0240T**, *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with high resolution esophageal pressure topography*, and **0241T**, *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during high resolution esophageal pressure topography study (e.g., stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)*, have been deleted. To report esophageal manometry with high resolution esophageal pressure topography, use codes 91299. To report esophageal manometry, report 91010, 91013, as appropriate.

Endoscopic Mucosal Resection

Endoscopic mucosal resection (EMR) includes cap-assisted or ligation-assisted (banding) removal of a lesion, along with injection-assisted snare removal techniques. Whether performed in the upper or lower GI tract, EMR requires the lift technique to create a space beneath the lesion to isolate the lesion from underlying submucosa, which allows for a more complete removal that is safer in terms of bleeding and perforation risk, and the use of a specialized device to isolate the tissue to be removed. Coding for EMR procedures requires the performance of 1) submucosal injection to lift the lesion; 2) demarcation of the lesion, often by creating a pseudopolyp out of tissue; AND 3) endoscopic snare resection. If all three components are not performed, it is not appropriate to report an EMR procedure; rather, service(s) performed (submucosal injection, snare polypectomy) are reported, with modifier 59 on the secondary procedure(s). When biopsy is performed on the same lesion as EMR, biopsy is not reported. Likewise, ablations of the edges of the lesion, clipping of the defect or other bleeding treatment to the same lesion are not separately reported.

Colonoscopy

The definition of a colonoscopy examination was revised in calendar year 2015. Colonoscopy is now defined 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.

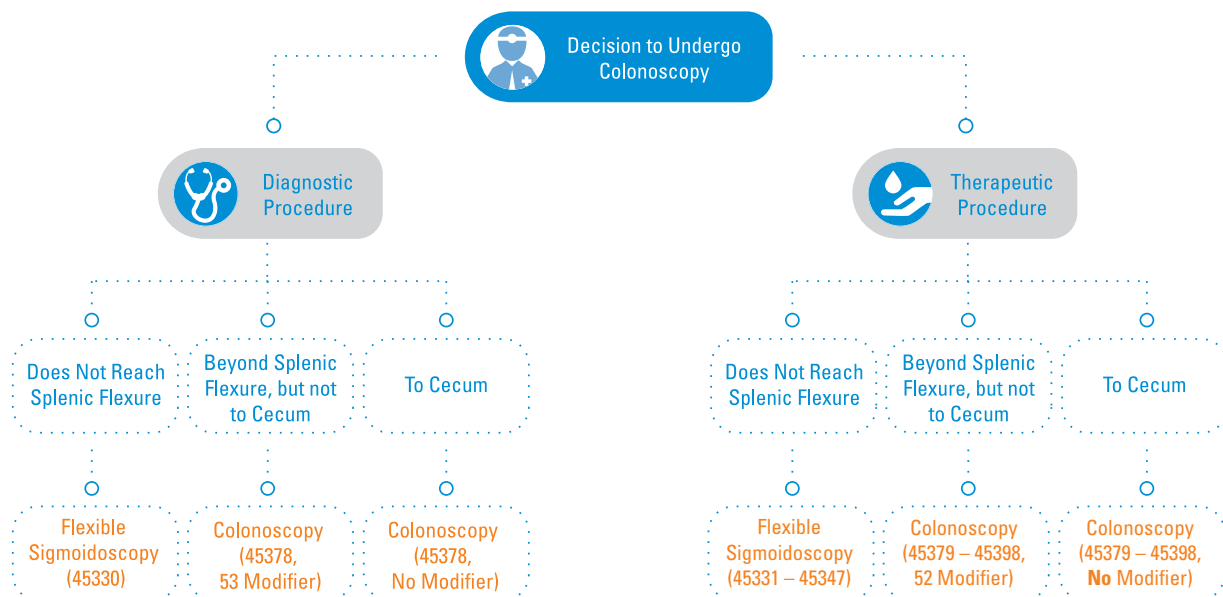
- ▶ When performing a *diagnostic or screening* endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) 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.
- ▶ Report ileoscopy through stoma (44380, 44381, 44382, 44384) for endoscopic examination of a patient who has an ileostomy.
- ▶ For colonoscopy per rectum, see 45378-45398.

Reporting Examination of the Distal Defunctionalized Colon

CPT provides guidance on how to code for both endoscopic examination of the colon that remains above a stoma (colostomy) and, at the same time, examination of the bypassed or defunctionalized colon. If a patient has a colostomy, an exam from stoma to cecum would entail a colonoscopy through stoma (44388 series), and examination of the retained portions of the colon are coded with an anoscopy, proctosigmoidoscopy or flexible sigmoidoscopy code, as appropriate.

Colonoscopy Decision Tree

Page 295 of the *2016 CPT Professional Guide* contains the corrected Colonoscopy Decision Tree. When coding a therapeutic procedure to the cecum, bill the appropriate colonoscopy CPT code with no modifier. Please note that the “Diagnostic Procedure” decision node can include screening or diagnostic procedures.



FREQUENTLY ASKED CODING QUESTIONS

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QUESTION: When a bleeding ulcer is cauterized in the body of the stomach and a biopsy is taken from a separate area, code 43255 *Esophagogastroduodenoscopy (EGD) with control of bleeding*, is denied when billed with 43239-59, EGD with biopsy. How should we bill this?

ANSWER: Control of bleeding caused by an endoscopic procedure is bundled into every procedure. However, for control of bleeding for a separate site/lesion, use modifier 59 with 43255 (control of bleeding) in addition to the primary procedure.

QUESTION: How should we report an attempted endoscopic retrograde cholangiopancreatography (ERCP) when the common bile duct is not able to be cannulated or injected?

ANSWER: CPT instructs that the physician report this as an EGD procedure.

QUESTION: How do you report endoscopic ultrasound (EUS) with optical endomicroscopy (OE) and fine needle aspiration (FNA) of a pancreatic cyst?

ANSWER: The EUS/FNA procedure is reported using code 43238, *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)*, or code 43242, *Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)*, depending on whether the EUS is limited (43238) or includes the esophagus, stomach, AND duodenum (43242). The OE is reported using code 43252, *Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy*.

QUESTION: What is a diagnostic colonoscopy?

ANSWER: 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.

Standard insurance benefits apply. Payors may use external criteria for determining coverage/medical necessity of the procedure, such as MCG™ (formerly known as Milliman Care Guidelines), InterQual® and/or the [2012 ASGE Appropriate Use of Gastrointestinal Endoscopy Guidelines](#).

QUESTION: What are the indications for coverage of a preventive service?

ANSWER: For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of exchanges) to provide coverage for 10 categories of essential health benefits (EHBs). Large group plans (both self-funded and fully insured) and small group Administrative Services Only (ASO) plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits that are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all grandfathered and non-grandfathered plans. The determination of which benefits constitute EHBs is made on a state-by-state basis.

Effective for plan years on or after September 23, 2010, the federal Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered health plans to cover certain “recommended preventive services” as identified/

mandated by PPACA. These services are described in the [United States Preventive Services Task Force A and B recommendations](#), the [Advisory Committee on Immunization Practices](#) of the CDC, and [Health Resources and Services Administration](#) Guidelines, including the [American Academy of Pediatrics Bright Futures](#) periodicity guidelines.

QUESTION: Can plans impose cost-sharing for preventive services if the patient is seen by a non-network provider?

ANSWER: Yes

QUESTION: What are preventive colorectal cancer (CRC) screening services?

ANSWER: Preventive colorectal cancer screening services include CRC screening tests, such as fecal occult blood test (FOBT), fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, CT colonography, or Cologuard™. If a patient undergoes a CRC screening test by another health-care professional and an abnormality (e.g. positive test) is found that prompts referral for a colonoscopy, for Medicare, the colonoscopy is no longer a screening procedure and 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, as it is not appropriate to code Z12.11 or Z12.12 for the colonoscopy. Note that CT colonography is not a covered service for CRC screening for Medicare. Cologuard is a covered service for Medicare beneficiaries.

For commercial payors, check the medical policy to see whether CT colonography and/or Cologuard are covered services for CRC screening. Check the summary plan description (SPD) and/or payor policy to see if a colonoscopy performed in an asymptomatic patient with a positive FOBT, FIT, Cologuard, flexible sigmoidoscopy or CT colonography is or is not still a preventive service (with waiver of financial responsibility).

QUESTION: Can you explain the difference between average-risk and high-risk screening when submitting claims for screening colonoscopy?

ANSWER: Listed below are Medicare's definitions of average and high risk. Commercial payors may decide to follow Medicare policy on colorectal cancer (CRC) screening or use their own definitions. Check with the payor on their coding and coverage policies and benefits.

Screening: Lack of symptoms and abnormalities

According to Medicare, screening is, by definition, a service performed on a patient in the absence of signs and symptoms. Once the patient is diagnosed with polyps, even hyperplastic polyps, follow-up endoscopy is surveillance. Use the ICD-10 codes to identify surveillance.

Average and High Risk:

Medicare considers an individual at high risk for developing colorectal cancer as one who has one or more of the following:

- ▶ A close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp.
- ▶ A family history of familial adenomatous polyposis.
- ▶ A family history of hereditary nonpolyposis colorectal cancer.
- ▶ A personal history of adenomatous polyps.
- ▶ A personal history of colorectal cancer.
- ▶ Inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Average risk is a patient who does not meet the above criteria for high risk.

Medicare defines a close relative as first degree siblings, parents or children. Commercial payors may define family history to also include 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 high risk as these are not 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.

QUESTION: Some U.S. Preventive Services Task Force (USPSTF) recommendations apply to certain populations identified as high-risk. Some individuals, for example, are at increased risk for certain diseases, because they have a family or personal history of the disease. How can a plan or issuer determine when a service should or should not be covered without cost-sharing?

ANSWER: Identification of "high-risk" individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high-risk population, and should therefore receive a specific preventive item or service identified for those at high-risk, should be made by the attending provider. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, that service is required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).

QUESTION: Are there criteria for defining patients at increased/high-risk for colorectal cancer screening?

ANSWER: The National Comprehensive Cancer Network (NCCN) Guidelines® for detection, prevention and risk reduction provide the following definitions:

Positive family history of CRC:

- ▶ Individuals with a first-degree relative (i.e., full sibling, parent, child) age < 60 years with CRC, or two first-degree relatives with CRC at any age:
 - Colonoscopy should begin at age 40 or 10 years before earliest diagnosis of CRC and repeat colonoscopy every three to five years depending on individual family history.
- ▶ Individuals with a first-degree relative with CRC ≥ 60 years:
 - Colonoscopy should begin at age 50 or 10 years before earliest diagnosis of CRC and repeat colonoscopy every five years.
- ▶ Individual with one second degree relative with CRC < 50 years:
 - Colonoscopy should begin at age 50 and repeat colonoscopy per colonoscopy findings.
- ▶ First-degree relatives with advanced adenoma:
 - Colonoscopy should begin at age 50 or age of onset, whichever is first, then repeat colonoscopy per colonoscopy findings.

Personal or inherited risk of polyposis syndromes:

- ▶ Family history of familial adenomatous polyposis (FAP):
 - Individual is a genetic carrier:
 - Annual flexible sigmoidoscopy or colonoscopy, beginning at age 10 to 15.

- Genetic status is unknown:
 - Annual flexible sigmoidoscopy or colonoscopy, beginning at age 10 to 15, until age 24 then:
 - Repeat every two years until age 34.
 - Repeat every three years until age 44.
 - Then every three to five years thereafter.
- Individual is not a carrier:
 - Average-risk screening should occur.
- ▶ Family history of attenuated FAP (AFAP)
 - Individual is a genetic carrier:
 - Annual colonoscopy beginning in late teens, then every two to three years.
 - Genetic status is unknown:
 - Colonoscopy every two to three years beginning in late teens; if adenomas are found, annual colonoscopy.
 - Individual is not a carrier:
 - Average-risk screening should occur.
- ▶ MYH-associated polyposis (MAP):
 - Unaffected family member and family mutation known; with biallelic MUTYH mutation positive or not tested:
 - Begin colonoscopy at age 25 to 30, and then every two to three years if negative.
 - Consider upper endoscopy and side viewing duodenoscopy starting at age 30 to 35 years.
 - For personal history of MAP with small adenoma burden:
 - Colonoscopy and polypectomy every one to two years.
- ▶ Lynch syndrome:
 - MLH1 and MSH2 mutation carriers (Lynch syndrome):
 - Colonoscopy age 20 to 25, or two to five years prior to the earliest colon cancer, if it is diagnosed before age 25 years, and repeat one to two years.
 - MSH6 and PMS2 mutation carriers (Lynch syndrome):
 - Colonoscopy age 30 to 35 years and every two to three years, and then after age 40, every one to two years.

QUESTION: What are the CPT and ICD-10 codes for screening and surveillance colonoscopy?

ANSWER: Check with the payor as to which codes to bill the colonoscopy and the acceptable ICD-10 codes. Payors other than Medicare may allow additional ICD-10 codes for meeting criteria for screening and surveillance

colonoscopy.

- ▶ Billing for a screening colonoscopy in an average-risk patient:
 - G0121 (Medicare) or 45378 (Medicaid, commercial, exchange, Tricare) with the appropriate ICD-10 code for screening:
 - Z12.11 — encounter for screening for malignant neoplasm of colon.
 - Z12.12 — encounter for screening for malignant neoplasm of rectum.

- ▶ Billing for screening colonoscopy in a high-risk patient:
 - G0105 (Medicare) or 45378 (Medicaid, commercial, exchange, Tricare) with the appropriate ICD-10 code for screening:
 - K50 — Crohn’s disease.
 - K51 — ulcerative colitis.
 - K52.1 — toxic gastroenteritis and colitis.
 - K52.89 — other specified noninfective gastroenteritis and colitis.
 - K52.9 — noninfective gastroenteritis and colitis, unspecified.
 - Z85.038 — personal history of other malignant lesion of large intestine.
 - Z85.048 — personal history of other malignant lesion of rectum, rectosigmoid junction and anus.
 - D12.6 — benign neoplasm of colon, unspecified.
 - Z15.09 — genetic susceptibility of other malignant neoplasm.
 - Z80.0 — family history of malignant neoplasm of digestive organs.
 - Z83.71 — family history of colonic polyps.
 - Z86.010 — personal history of benign neoplasm of colon.

QUESTION: Is anesthesia covered for screening colonoscopy?

ANSWER: Yes. Medicare and the departments (Labor, Treasury, Health and Human Services) have expanded the waiver of co-pay and deductible to include anesthesia for screening colonoscopy. Modifier 33 should be added to the 00810 anesthesia code to indicate the circumstance was preventive. In the circumstance when a screening procedure becomes therapeutic, the PT modifier should be applied to the anesthesia service. A co-pay will still apply, but the deductible should be waived.

QUESTION: Is a pre-procedure evaluation and management (E/M) visit covered prior to a screening colonoscopy?

ANSWER: Effective December 23, 2015, for patients other than Medicare, if a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF’s recommendations, it is not permissible for a plan or issuer to impose cost sharing for the required specialist consultation prior to the screening procedure. According to the departments, the plan or issuer may not impose cost sharing with respect to a required consultation prior to the screening procedure if the attending provider determines that the pre-procedure consultation would be medically appropriate for the individual, because the pre-procedure consultation is an integral part of the colonoscopy. As with any invasive procedure, the consultation before the colonoscopy can be essential in order for the consumer to obtain

the full benefit of the colonoscopy safely.

QUESTION: Is pathology covered when a lesion is found during a screening colonoscopy?

ANSWER: During a screening colonoscopy, polyps or other lesions can be found, which are biopsied or removed. Effective December 23, 2015, for patients other than Medicare, the departments have clarified that such services performed in conjunction with a preventive colonoscopy must be covered without cost sharing.

- ▶ For commercial payors, add modifier 33 to the surgical claim; use of this modifier 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.

Section 1834(d)(3)(D) of the Social Security Act states that, “[i]f during the course of such a screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.”

- ▶ As a result, when an anticipated screening colonoscopy ends up involving a biopsy or polyp removal, Medicare cannot pay for this procedure as a screening colonoscopy.
- ▶ 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 beneficiary is now responsible for the 20 percent co-pay.
- ▶ Similarly, the beneficiary is responsible for paying the Part B coinsurance for the covered anesthesia.

QUESTION: What are the recommendations for surveillance intervals?

ANSWER: If the screening colonoscopy on an average-risk patient is negative, Medicare allows a follow-up colonoscopy every 10 years through age 75. The frequency for follow-up for commercial payors is dependent upon the plan's summary plan document (SPD), but most follow either CMS policy or the U.S. Multi-Specialty Task Force (MSTF) recommendations.

No polyps, or hyperplastic polyps in rectum/sigmoid		
Repeat in 10 years		
Neoplasia found		
Serrated polyps/lesions	High risk adenomas	Low risk adenomas
Serrated polyposis Repeat in 1 year	> 10 Adenomas Repeat in less than 3 years	1–2 Tubular adenomas < 10 mm Repeat in 5–10 years
≥ 10 mm or With dysplasia or traditional serrated adenoma Repeat in 3 years	3–10 Adenomas Repeat in 3 years	
< 10 mm in Proximal colon and without dysplasia Repeat in 5 years	Villous adenoma(s) or tubular adenoma(s) ≥ 10 mm Repeat in 3 years	
	Adenoma(s) with high grade dysplasia Repeat in 3 years	

These recommended intervals assume a complete exam to cecum, adequate bowel prep, and complete removal of polyps at the baseline exam.

Source: Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer Gastroenterology 2012;143:844–857; doi:10.1053/j.gastro.2012.06.001; published online 03 July 2012

Medicare beneficiaries at high risk for developing colorectal cancer are eligible for follow-up colonoscopy once every 24 months.

QUESTION: What is the definition of screening vs. surveillance for commercial payors?

ANSWER: Payors may have policies that 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.

- ▶ 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.

QUESTION: What is the difference regarding the use of modifiers 52 and 53 with regards to upper and lower endoscopic procedures?

ANSWER: EGD procedures: To report esophagogastrosopy 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 1:** 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 2:** 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:

Example 1: 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 2: A 70-year-old male is 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 3: A 65-year-old female, asymptomatic, is 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 4: A 54-year-old is 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. However, once a biopsy was performed, it became therapeutic. Since it was also incomplete, modifier 52 is reported.

QUESTION: What can we do when payors deny anesthesia services as routine?

ANSWER: Anesthesia is a covered service without patient financial responsibility if the colonoscopy is a preventive service. If the endoscopy is not a preventive service, Medicare contractors, Medicaid and commercial payors may

have policies that only allow payment for anesthesia when the comorbidities/risk factors are submitted as the primary diagnoses and the documentation to meet the criteria is contained in the anesthesia assessment. It is essential that both the physician and anesthesia professional provide appropriate documentation to support the need for monitored anesthesia care.

QUESTION: We have some patients who are seen in the hospital by both the mid-level provider and physician on the same day. What type of documentation is required by the physician in order to bill under the name of the physician?

ANSWER: Since “incident to” services don’t apply to the hospital visits, what you are referring to is called “split-shared” billing. CMS requires a “substantive” portion of the history, exam and/or decision making to be documented by the physician in order to bill under his/her name. An addendum to the mid-level providers documentation that states “seen and agree” or a simple co-signature is not enough to bill under the name of the physician. If there is no supporting documentation, the visit should be billed under the mid-level provider.