CMS 2015 G-Codes for Lower GI Endoscopy Procedures
Frequently Asked Questions

Q: Why did CMS create G-codes in 2015 for some lower GI endoscopy procedures?

A: In the Medicare Physician Fee Schedule (MPFS) Final Rule for calendar year (CY) 2015, CMS delayed the implementation of the revaluation of colonoscopy and the other lower GI endoscopy codes. As a result, CMS decided to not recognize new 2015 CPT codes for physicians reporting lower GI endoscopy procedures, and maintained the 2014 rates for 2015.

However, some of the new 2015 CPT codes were created for existing procedures (e.g., stent, ablation) that required a new CPT code assignment because of significant changes to the language of the code descriptor. For those existing procedures with new CPT codes, CMS created G-codes using the 2014 code descriptions and crosswalked the reimbursement of the G-codes to the 2014 rates. G-codes are procedure codes developed by CMS to identify products, supplies and services not included in the CPT codes for which there is a programmatic operating need to separately identify them on a national level.

For example, in 2014, colonoscopy with ablation is coded using 45383 (*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*). For 2015, the new CPT code for this procedure is 45388, because the language "(includes pre- and post-dilation and guide wire passage, when performed)" was added. As CMS decided to not recognize the new 2015 CPT codes for GI endoscopy procedures, the agency created HCPCS code G6024 using the 2014 CPT descriptor and valued it using the 2014 physician work relative value units (RVUs) at 5.86 RVUs.

The table below provides the crosswalks from the 2014 CPT code to the 2015 CMS G-code. It is important to note that use of the G-codes is required for Medicare. Practices should check with their commercial and Medicaid payors to determine whether the 2015 CPT or G-codes should be reported.

2014 CPT Code	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)

2014 CPT Code	2015 HCPCS Code	Long Descriptor
44799	G6021	Unlisted procedure, intestine
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 chemical agent enhancement); with biopsy(ies)

Q: When should we use the G-codes?

A: Physicians should report the G-codes to original (fee-for-service) Medicare and Medicare Advantage plans. Facilities (hospital and ASC) should report the 2015 CPT codes, regardless of whether the patient is Medicare or not. Check with your commercial payors to determine if they will recognize the 2015 CPT codes for the new procedures.

Q: How long will physicians have to use G-codes to report lower GI endoscopy procedures to Medicare plans?

A: At present, the G-codes will be required for CY 2015. We anticipate that CMS will implement new values for all lower GI endoscopy procedures, including colonoscopy, in the 2016 Medicare Physician Fee Schedule. It is up to CMS as to when they will adopt the new CPT codes and values and delete the corresponding G-codes.

Q: Not all new CPT codes have a G-code crosswalk. Why?

A: When CMS delayed the implementation of the revaluation of colonoscopy and the lower GI endoscopy codes, they decided to not recognize the new 2015 CPT codes for lower GI endoscopy procedures. CMS only created G-codes for existing lower GI endoscopy procedures that were assigned new codes in CPT 2015. CMS set the value of the other new 2015 CPT codes to 0.00 RVUs. Agency staff has advised the GI societies to report the new procedures the way they were reported in 2014. The table below provides a crosswalk from the 2015 CPT code to the appropriate code combination to report for Medicare beneficiaries. Check with your commercial payors to determine if they recognize the 2015 CPT codes for the new procedures.

Q: How should I report a new CPT code that does not have a G-code crosswalk to Medicare?

A: The table below provides a crosswalk from the 2015 CPT code to the appropriate code combination to report physician services provided for Medicare beneficiaries. It is important to note that use of the CPT and G-code combination crosswalks are only required for physician services provided to Medicare beneficiaries; facilities should report the 2015 CPT code. Check with your commercial payors to determine if they recognize the 2015 CPT codes for the new procedures. Note that as CMS created G6021 to replace 44799, Unlisted procedure, intestine, code G6021 should be used to report the additional service (e.g., dilation, EMR, EUS, band ligation, etc.) not captured by the base code.

CPT 2015 Code	Description	CMS CY 2015 Crosswalk for Medicare Plans
44381	Ileoscopy w/dilation	44380, G6021
44403	C-stoma w/endoscopic mucosal resection (EMR)	44388, G6021
44404	C-stoma w/submucosal injection	44388, G6021
44405	C-stoma w/dilation	44388, G6021
44406	C-stoma w/endoscopic ultrasound (EUS)	44388, G6021
44407	C-stoma w/EUS-guided fine needle aspiration (FNA)	44388, G6021
44408	C-stoma w/decompression	44388, G6021
45349	Flexible sigmoid w/endoscopic mucosal resection (EMR)	45330, G6021
45350	Flexible sigmoid w/band ligation (e.g. hemorrhoids)	45330, G6021
45390	Colonoscopy w/endoscopic mucosal resection (EMR)	45378, G6021
45393	Colonoscopy w/decompression	45378, G6021
45398	Colonoscopy w/band ligation (e.g. hemorrhoids)	45378, G6021

Q: Are G-codes supposed to be used for Medicare only or do I need to use them for commercial plans too?

A: Reporting lower GI endoscopy codes in 2015 will depend on status of the patient (e.g., commercial, Medicare Advantage, traditional fee-for-service Medicare, Medicaid, Tricare, exchange). The new G-codes were created by CMS specifically for reporting certain lower GI endoscopy procedures provided to Medicare beneficiaries. Commercial plans may not recognize these HCPCS G-codes. Check with your commercial payors for guidance on how to report the new 2015 CPT codes for non-Medicare lines of service.

Q: How can I determine when to report the G-codes and when to use the new 2015 CPT codes?

A: The following may be helpful in determining when to report CPT and G-codes for 2015.

If the patient is Medicare (fee for service, Medicare Advantage), ***and***:

- If the code has not changed from 2014 to 2015:
  - Physicians report the CPT code and CMS fees are based on 2014 values.
- If the code has changed from 2014 to 2015:
  - Physicians report the G-code and CMS fees are based on 2014 values.
- If the code is new for 2015:
  - Do not report the CPT 2015 codes; they are not valued by CMS.
  - Physicians report the CY 2014 CPT code(s).

Q: The patient is a dual eligible, Medicaid–Medicare patient. What do I report?

A: The use of the CPT and G-code combination crosswalks are only required for physician services provided to Medicare beneficiaries; facilities should report the 2015 CPT code. Check with your Medicaid plan to determine if they recognize the 2015 CPT codes for the new procedures.

Q: Is there commercial payment guidance for new lower GI procedure codes that CMS did not assign values for in the 2015 MPFS fee schedule?

A: Not all payors have decided 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 might be helpful to look at the 2014 RVU values for the base codes and the 2015 value of the increment from the analogous upper GI endoscopy procedure. For example, the Medicare increment for the physician work of a stent above the upper GI endoscopy base codes is 1.98. Look at what you are getting paid by the commercial payor, for example 43266 (EGD with stent) compared to the base code 43235 (EGD). This increment can be added to a lower GI endoscopy base code to calculate a physician work RVU for the new stent codes as a point of reference for reimbursement discussions with commercial payors.

Procedure	CMS wRVU Increment over base code
Submucosal injection	0.30
Balloon dilation	0.58
Endoscopic ultrasound (EUS)	1.38
Stent (includes dilation + guide wire)	1.98
Ablation (includes dilation + guide wire)	2.07
EUS with fine needle aspiration (FNA)	2.07
Endoscopic mucosal resection (EMR)	2.78
Banding	1.40
Decompression	1.02