LOWER GI ENDOSCOPIES

We have lots of changes to lower GI coding for 2015 to talk about. Code definitions have been revised and many new codes have been added to this chapter. First the good news:

All these codes were reviewed by CMS in cooperation with the AMA’s Specialty Society Relative Value Scale Update Committee (RUC). The review was undertaken to:

- Reflect technology, devices, and techniques in current use
- Standardize language and code descriptions across all GI endoscopy sections
- Support “multiple endoscopy rule” concepts

Unfortunately we also have some bad news to report which impacts how CMS will reimburse physicians for the new 2015 codes. Simply put, the new CPT codes will not be recognized by Medicare for physician reimbursement in 2015.

What does this mean to your facilities and practices? Briefly it means:

- CMS will continue to reimburse physicians at CY 2014 levels for these procedures;
- Physicians will report G codes instead of the new CPT codes (see the crosswalk table below);
- Facilities will report the new codes and should encounter no problems with Medicare reimbursement;
- Private payors should recognize the new 2015 CPT codes for BOTH facility and provider payments

So why is CMS yanking our chain?

Ok, CMS has made it confusing for physicians to report colonoscopy services, but they have their reasons. In fact, several professional gastroenterology groups requested that CMS delay final review of the endoscopy codes until the Agency adopts a more transparent rate-setting process and establishes a clear direction on valuing services where moderate sedation is inherent to the procedure. CMS agreed, stating:

“In light of the substantial nature of this code revision and its relationship to the policies on moderate sedation, CMS is delaying revaluation of the colonoscopy codes until CY 2016 when we will be able to include proposals in the proposed rule for their valuation, along with consideration of policies for moderate sedation. Accordingly for CY 2015, we are maintaining values for the lower gastrointestinal endoscopy codes at the CY 2014 levels.”

CMS has created G-codes for 10 services that had CPT codes in 2014 that changed in 2015 to allow physicians to report services to CMS in 2015 the same way they did in 2014 and at 2014 valuations. CMS will require physicians to report the G-code instead of the corresponding 2015 CPT code for existing procedures that have new CPT code assignments in CPT 2015.

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. For 2015 the same terminology changes were made to ileoscopy, poucoscopy, flexible sigmoidoscopy, colonoscopy through stoma, and colonoscopy.
Endoscopy Definitions
Grab your 2015 CPT book and peruse the revised definitions for all lower GI endoscopies. You will see that colonoscopy is now defined as: “The examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis.” Read a bit further and you will see that we have a change in the description of what an INCOMPLETE colonoscopy is, and when to apply reduced service modifiers.

- For 2015, when performing a screening or diagnostic colonoscopy, if the scope cannot be advanced to the cecum or colon-small intestine anastomosis, report the colonoscopy code with the appropriate modifier 74 or 53. This is a change from the current instructions which allow the reduced service modifier if the scope cannot be advanced beyond the splenic flexure. Do not report modifier -52 on screening codes.

- For therapeutic exams that do not reach the cecum (e.g. polypectomy, biopsy), report the colonoscopy code with modifier -52.

  EXAMPLE: The patient undergoes a complete colonoscopy with snare removal of a polyp in the transverse colon. Several days later the patient returns and the endoscopist tattoos the polypectomy site but does not advance the scope beyond the transverse colon. For this procedure append modifier -52.

- Report flexible sigmoidoscopy (45330-45347) for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure.

Appending -33 and –PT modifiers to anesthesia related to screening colonoscopies
This year CMS adopted a policy to define screening colonoscopy to include anesthesia so that beneficiaries do not have to pay coinsurance on anesthesia for a screening colonoscopy when furnished separately by an anesthesia professional. Currently Medicare waives the Part B deductible and coinsurance applicable to screening colonoscopy. Starting in 2015, CMS includes separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, further reducing beneficiaries’ cost-sharing obligations under Part B.

To report separate anesthesia services for screening colonoscopies on Medicare beneficiaries:

- Append modifier -33 – Preventive Services – to the anesthesia code 00810 for screening colonoscopies.

- If the procedure begins as a screening but further services such as polypectomy are performed, report 00810-PT - Colorectal cancer screening test; converted to diagnostic test or other procedure - for anesthesia services.

Key Lower GI Coding Concepts

Placement of stent
New stent codes now include pre-dilation, post-dilation, and guide wire passage if performed. Report placement of stent 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.
**Control of Bleeding**
Previous code descriptors for control of bleeding 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. As with the stent codes, do not add a reduced service modifier if all components are not performed.

**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 for the same lesion is not appropriate, as all these services are now bundled into the code for EMR. When biopsy is performed on the same lesion as EMR, do NOT report the biopsy separately. This procedure is most often performed on large flat lesions that cannot be excised without first lifting them away from the intestinal mucosa.

**Pouchoscopy Overview**
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.

**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.

**Colonoscopy Through Stoma**
Colonoscopy through stoma is newly defined as 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 colonoscopy through stoma on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the scope to the cecum due to unforeseen circumstances, report 44388 with modifier 74 or 53. For therapeutic examinations that do not reach the colon-small intestine anastomosis, report the appropriate colonoscopy through stoma code with modifier 52 with 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.

**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.
The best way to learn about the new codes for 2015 is to review your new CPT book, look for the “new code” red bullets: ●, and start reading. Here are the codes to focus on from the lower GI section:

- 44381
- 44384
- 44401 through 44408
- 45346

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<tr>
<td>44381</td>
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<td>44384</td>
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<td>44401 through 44408</td>
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<td>45346</td>
<td>45388 through 45399</td>
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**Lower Gastrointestinal Endoscopy G-Codes Replacing CY 2015 CPT Codes**

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<tr>
<td>44383</td>
<td>G6018</td>
<td>Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)</td>
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<td>44393</td>
<td>G6019</td>
<td>Colonoscopy through stoma; with ablation of tumor(s), polyp(s) or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cauter or snare technique</td>
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<tr>
<td>44397</td>
<td>G6020</td>
<td>Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)</td>
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<td>44799</td>
<td>G6021</td>
<td>Unlisted procedure, intestine</td>
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<td>45399</td>
<td>G6022</td>
<td>Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cauter or snare technique</td>
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<tr>
<td>45345</td>
<td>G6023</td>
<td>Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)</td>
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<tr>
<td>45383</td>
<td>G6024</td>
<td>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 cauter or snare technique</td>
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<tr>
<td>45387</td>
<td>G6025</td>
<td>Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)</td>
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<td>0226T</td>
<td>G6027</td>
<td>Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed</td>
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<tr>
<td>0227T</td>
<td>G6028</td>
<td>Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)</td>
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So, one more time, just to clarify, for 2015 report endoscopy codes as follows:

**FACILITIES:**
- Report the 2015 CPT codes
  - Regardless of whether the code is new or has not changed
  - Regardless of payor
- DO NOT report the G codes as they have not been valued in the OPPS system fee schedule.

**PHYSICIANS:**

**Medicare**
- **If the code has NOT changed from 2014 to 2015:**
  - Report the CPT code.
  - Payment will be at 2014 level.

  **If code has changed from 2014 to 2015 OR if the code is NEW for 2015:**
  - Physicians report one of the G codes from the above table.
  - Payment will be at 2014 level.

**Other Payors**
- Report the 2015 CPT code unless otherwise instructed by the payor.