

New CPT Codes for 2009

Glenn D. Littenberg, MD, ASGE CPT Advisor

Joel V. Brill, MD, AGA CPT Advisor

Daniel C. DeMarco, MD, ACG CPT Advisor

A number of coding-related issues of importance to gastroenterologists for 2009 will be discussed in this article. Although there is only one new CPT* code for 2009 for GI endoscopy for direct cholangioscopy/pancreatoscopy and one new Physician Quality Reporting Initiative (PQRI) code for endoscopy and polyp surveillance, there are other coding changes that may be of interest to the gastroenterology community:

- New code for cholangioscopy/pancreatoscopy
- New code for hemorrhoid management using thermal energy
- New code for laparoscopic Heller myotomy
- CPT codes deleted in 2009
- Review of low-volume gastroenterology procedures
- Clarification of evaluation/management (E/M) procedures
- Renumbered codes for infusion services
- G-codes to describe follow-up inpatient telehealth consultations
- Reminder about telephone services and Medicare policy
- PQRI codes

Endoscopic retrograde cholangiopancreatography (ERCP) coding – cholangioscopy/pancreatoscopy

For 2009, CPT has established a new code to report direct visualization cholangioscopy/pancreatoscopy:

+ 43273 *Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure)*

(Use 43273 in conjunction with 43260, 43261, 43263-43265, 43267-43272)

This procedure is performed in conjunction with ERCP procedure(s). Code 43273 is the first GI endoscopy code to have an “add on” structure. This means that code +43273 must be reported in conjunction with other ERCP codes (43260, 43261, 43263-43265, 43267-43272). Because it is an add-on code, its value is not reduced by the multiple surgical services or multiple endoscopy service rules.

Code +43273 is reported only once, whether the bile duct(s) and/or pancreatic duct are examined. Note that the code is always reported in conjunction with one or more ERCP procedure codes. The most common clinical scenarios are biopsy, stent or other therapeutic procedures that are performed via ERCP during the same session as cholangioscopy/pancreatoscopy; these would then be the basic ERCP code(s) to report.

For CPT 2009, if an ERCP is performed with sphincterotomy and then direct cholangioscopy is performed, one can either report 43260 and 43273 or report 43260

with a modifier **22** *Increased Procedural Services* to reflect the “highly unusual work” beyond the usual work of 43260.

CMS has valued code 43273 code at 2.24 Work RVUs (Relative Value Units). The 2009 Medicare national fee schedule payment for this service is \$125.51 when performed in the facility setting.

Revised code for hemorrhoid management using thermal energy

The hemorrhoid therapy codes have been revised for CPT 2009 to reflect contemporary practice. The “any method” codes ~~46934-46936~~ have been deleted and replaced with a single code that is specific for destruction of hemorrhoids using thermal energy:

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

Code 46221 *Hemorrhoidectomy, by simple ligature (e.g., rubber band)*, remains as another code used by gastroenterologists (in conjunction with sigmoidoscopy).

The global period for code 46930 is 90 days, which means that if the patient is brought back during the global period for a second or subsequent thermal energy procedure, a modifier will need to be applied for the subsequent service to be considered. Physicians may wish to consider the use of modifier 76:

76 Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

The 2009 Medicare national fee schedule payment for code 46930 is \$137.41 when performed in the facility setting and \$189.71 when performed in the physician’s office.

New laparoscopic code for Heller myotomy

The 2009 CPT codebook contains a new code to report a laparoscopic Heller myotomy for achalasia therapy:

- 43279 *Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed*

(For open approach, see 43330, 43331)

Codes deleted in 2009

For CPT 2009, there is one code deletion (91100) that should have minimal impact on gastroenterology:

91100	Intestinal bleeding tube, passage, positioning and monitoring
	<u>(91100 has been deleted)</u>
	<u>(To report placement of an esophageal tamponade tube for management of variceal bleeding, use 43460. To report placement of a long intestinal Miller-Abbott tube, use 44500)</u>

Review of low-volume gastroenterology codes

The GI societies are performing a comprehensive review of obsolete and/or very low volume codes for GI physiologic services. Once the analysis has been completed, the societies may make a recommendation to delete or modify these codes. Note that the codes being reviewed are GI physiologic tests and do not involve any endoscopy or motility services.

Clarification of Evaluation and Management (E/M) language

Although there are no major changes made to any of the existing E/M codes, there is new language in the Guidelines section of the CPT codebook to broaden the sense of the word “physician” as follows:

(E/M) services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

This clarification should be helpful to physicians who work with nurse practitioners and physician assistants in their practice settings.

In CPT 2009, we may see clarification of the difference between a consultation service and transfer of care. This is a problem that the GI societies, along with the American Medical Association (AMA) and a number of other specialty societies, have addressed with Medicare.

Of concern is that E/M services may be a target in retrospective chart reviews performed by the Medicare Recovery Audit Contractors (RAC) program. While the RAC contractors are not allowed to look for improper payments made prior to October 1, 2007, the RAC activities supplement other review efforts by Medicare contractors, program safeguard contractors and the benefit integrity support centers, which are not restricted in their look-back period.

The RAC contractors have the ability to review any types of claims, including E/M; however, the topics chosen for audit must be approved by Centers for Medicare and Medicaid Services (CMS). Physicians will need to provide medical records to a RAC contractor upon request, with no compensation for copying costs. CMS is imposing limits on the number of records that may be reviewed based on the size of a physician’s practice.

Renumbered codes for infusion services

In 2009, CPT codes for certain therapeutic infusion services have been renumbered. The new codes that are pertinent to gastroenterology include:

- 96360 – *Intravenous infusion, hydration; initial 31 minutes to 1 hour* (old 90760)
- 96361 – *Intravenous infusion, hydration; each additional hour* (List separately in addition to code for primary procedure) (old 90761)

- 96365 – *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour (old 90765)*
- 96366 – *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) (old 90766)*
- 96372 – *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (old 90772)*
- 96373 – *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial (old 90774)*

G-codes to describe follow-up inpatient telehealth consultations

Medicare policy allows for coverage and payment for telehealth services. Medicare telehealth includes consultation, office visits, individual psychotherapy, pharmacologic management and any additional services specified by the Secretary of Health and Human Services delivered via a telecommunications system. CMS maintains a list of eligible telehealth services that is updated on a yearly basis.

For Calendar Year 2009, CMS has established a new series of the Healthcare Common Procedure Coding System (HCPCS) codes for follow-up inpatient telehealth consultations. Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to complete an initial consultation or subsequent consultative visits requested by the attending physician. CMS has established the following G-codes:

- G0406, Follow-up inpatient telehealth consultation, limited, typically 15 minutes communicating with the patient via telehealth
- G0407, Follow-up inpatient telehealth consultation, intermediate, typically 25 minutes communicating with the patient via telehealth
- G0408, Follow-up inpatient telehealth consultation, complex, typically 35 minutes or more communicating with the patient via telehealth

The service must be reported with a HCPCS modifier GT *via interactive audio and video telecommunications system*. In certain circumstances the code can be reported in conjunction with a GQ *via asynchronous telecommunications system* modifier.

Telephone Services and Medicare Policy

In 2008, new CPT codes were released for telephone services and on-line services. In the past, telephone services were regarded as bundled into E/M services and thus not separately reportable. During 2008, CMS clarified that the new codes would be considered “non-covered,” a subtle but important difference – namely, that (like preventive services) they *can* be billed to Medicare patients, without the need for Advanced Beneficiary Notice (ABN) and without a limiting charge.

However, to bill Medicare beneficiaries for these codes, it is very important to follow the ground rules for these services as described in detail in CPT and to document carefully. It

is sensible to give notice to patients about a change in your practice policy if you decide to begin charging for certain telephone and/or online services but had not done so in the past.

Physicians are advised to review the introductory and parenthetical language in the CPT codebook for Non-Face-to-Face Physician Services that refer to codes 99441-99443 and 99444 to understand the ground rules:

Telephone services are non-face-to-face evaluation and management (E/M) services provided by a physician to a patient using the telephone. These codes are used to report episodes of care by the physician initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather, the encounter is considered part of the pre-service work of the subsequent E/M service, procedure and visit. Likewise if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if reporting 99441-99444 performed in the previous seven days.)

An on-line electronic medical evaluation is a non-face-to-face evaluation and management (E/M) service by a physician to a patient using Internet resources in response to a patient's on-line inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a seven-day period, although multiple physicians could report their exchange with the same patient. If the on-line medical evaluation refers to an E/M service previously performed and reported within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.

Physician Quality Reporting Initiative (PQRI)

For 2009, CMS has established a new PQRI quality measure, Endoscopy & Polyp Surveillance: Surveillance Colonoscopy Interval in Patients with History of Adenomatous Polyps.

This measure looks at the percentage of patients aged 18 years and older undergoing a surveillance colonoscopy, with a history of a colonic polyp on previous colonoscopy findings, who had a follow-up interval of three or more years since the last colonoscopy

documented in the colonoscopy report. The details regarding this measure and specifications will be posted by CMS at www.cms.hhs.gov/pqri.

CMS has eliminated the Gastroesophageal Reflux Disease (GERD) measure from the 2009 PQRI program. The e-prescribing measure (#125) has been deleted from PQRI and placed into a separate incentive program.

Existing measures that may be of interest to gastroenterology that have been carried into the 2009 PQRI program are:

- ▶ Measures 83-90 – Treatment and Management of Hepatitis C
- ▶ Measure 113 – Colorectal Cancer Screening
- ▶ Measure 124 – Health Information Technology (HIT) – Adoption/Use of Health Information Technology (Electronic Health Records)
- ▶ Measure 128 – BMI Screening

For 2009, CMS has established paired PQRI measures. A measure set consists of two closely related individual measures that are composed of two similar and complementary aspects of care. For the 2009 PQRI, CMS does not require that the measures paired in a measure set be reported together.

However, under the measures validation strategy for eligible professionals that report less than three measures, failure to report the additional measure(s) in a valid set would cause the eligible professional to fail to meet the validation requirements.

The hepatitis C paired measures are:

- ▶ Hepatitis A and B Vaccinations
- ▶ Hepatitis C RNA Testing before Initiating Treatment and HCV Genotype Testing Prior to Treatment

Any CPT-related questions or concerns for advisors can be directed to appropriate specialty society staff.

Glenn D. Littenberg, MD

sheila@marcassoc.com

Joel V. Brill, MD

jconte@gastro.org

Daniel C. DeMarco, MD

bstillman@acg.gi.org

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