Preview: Changes to Coding for Lower GI Endoscopy Procedures in 2015

There are significant changes to coding for lower GI endoscopic procedures ahead 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.

This article provides an overview of the changes to GI lower endoscopy codes as proposed by the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and American Society for Gastrointestinal Endoscopy (ASGE), the American College of Surgeons (ACS), the Society of American Gastrointestinal Surgeons (SAGES) and the American Society of Colon and Rectal Surgeons (ASCRS) to the American Medical Association (AMA) CPT Editorial Panel, the body responsible for maintaining and updating the CPT code set. The information reflects the societies’ proposed revisions and subsequent changes that have been discussed at recent CPT Editorial Panel meetings. A Summary of Panel Actions from each CPT Editorial Panel meeting is available at the AMA’s website. The complete 2015 CPT files, containing full code descriptors and instructional information is expected to be released in late August. The changes will become effective on January 1, 2015.

In the 2011 Final Rule, CMS identified a number of endoscopic procedures, including colonoscopy, for review of physician work and practice expense. Section 3134 of the Affordable Care Act gives the Secretary of the Department of Health and Human Services the authority to regularly review Medicare fee schedule rates for physician services to identify potentially misvalued codes, which can include procedures with fast growth, substantial change in practice expense, new technologies or services, multiple codes frequently billed together, codes with low relative values, and Harvard-valued codes. The upper GI endoscopy changes were implemented last year. As of CPT 2015, the majority of GI endoscopy code families will reflect current terminology and practice.

Following approval by the CPT Editorial Panel, the codes were surveyed by the specialty societies, and presented to the AMA/Specialty Society Relative Value Update Committee (RUC). While the RUC makes recommendations to CMS, CMS is the only entity that makes relative value decisions regarding physician work, practice expense, and professional liability.

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.

Source: American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy
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 for the same lesion 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.

**Enteroscopy Overview**
A new definition and instructions for reporting antegrade transoral small intestine endoscopy (ie, enteroscopy) will be 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).

*Source: American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy*
To report retrograde examination of small intestine via anus or colon stoma, use 44799, Unlisted procedure, small intestine.

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

**Pouchoscopy Overview**
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.

**Flexible Sigmoidoscopy Overview**
Specific instructions for reporting flexible sigmoidoscopy will be 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 Overview**
Colonoscopy through stoma will be 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 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 due to unforeseen circumstances, report 44388 with modifier 53 with appropriate documentation. 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.

**Colonoscopy Overview**
The definition of a colonoscopy examination will be specifically defined in CPT as the examination of the entire colon, from the rectum to the cecum, and may include examination of the terminal ileum or small intestine proximal to an anastomosis. When performing a colonoscopy 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 with modifier 53 with appropriate documentation. For therapeutic examinations that do not reach the cecum, report the appropriate colonoscopy code with modifier 52 with appropriate documentation.

New codes for the colonoscopy family include endoscopic mucosal resection, band ligation, 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.

*Source: American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy*