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Welcome to PMI's Webinar Presentation:

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GI Coding Update

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GI Coding Update

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Agenda

- New K Codes
- New and deleted CPT®
- No Surprises Act & GFE requirements
- Proper Modifier Usage
- Coding surgical procedures

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Updates for Gastroenterology Coding

INTRODUCTION

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The Business of GI

- Understanding the business side of medicine helps physicians run a successful practice.
- Just as in any other business, understanding money matters is critical to running a successful medical practice.
- Gastroenterologists provide both medical and surgical services and face complex coding and billing challenges.
- The COVID-19 pandemic has exacerbated these challenges.

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- According to Medscape's 2021 Gastroenterologist Compensation Report, 52% of self-employed gastroenterologists saw a 1-25% decline in patient volume that they consider permanent.
- With gastro-specific office/outpatient E/M services and new payer regulations in 2021, such support can be crucial for practices to improve their bottom line.

https://www.medscape.com/slideshow/2021-compensation-gastroenterologist-6013849#3

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2022 conversion factor and impact to GI

- The CY2022 PFS conversion factor is $33.59, a decrease of $1.30 from the CY 2021 PFS conversion factor of $34.89.
- The PFS conversion factor reflects the expiration of the 3.75 percent payment increase provided for CY2021 by the Consolidated Appropriations Act.
- This congressional intervention averted a significant cut in Medicare physician payment that would have resulted in an almost 10 percent payment cut to GI services on average.
- Your GI societies will be working to secure congressional action to avert cuts to physician payments next year as physician practices across the country continue to recover from the pandemic.

https://gastro.org/news/2022-proposed-medicare-payment-policies-released/

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Payment charts for GI

CY 2022 payment changes for GI

CY 2022 RVU changes for GI

Charts can be found in the additional handouts

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New CPT codes and values for POEM and colon capsule endoscopy

- CMS finalized a valuation of 13.29 physician work relative value units (wRVUs) for POEM and 2.41 wRVUs for colon capsule endoscopy.

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Implementation of the Removing Barriers to Colorectal Cancer Screening Act

- CMS plans to implement changes made last year by Congress to beneficiary cost-sharing obligations when a polyp or other growth is found and removed as part of a screening colonoscopy or screening flexible sigmoidoscopy.
- Currently, any additional procedure beyond the planned colorectal preventive screening services results in a patient having to pay coinsurance.
- Beginning Jan. 1, 2022, beneficiary coinsurance will be 20 percent, phasing out to zero by Jan. 1, 2030.

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Billing for physician assistant (PA) services

- CMS is implementing a change in statute to remove the requirement to make payment for PA services only to the employer of a PA effective Jan. 1, 2022.
- With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services as do nurse practitioners (NPs) and clinical nurse specialists (CNSs) currently.
- Effective with this amendment, PAs also may reassign their rights to payment for their services and may choose to incorporate as a group composed solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs now may do.

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Changes to the Quality Payment Program

MIPS Value Pathways

- CMS will begin transitioning to MVPs in the 2023 MIPS performance year.
- MIPS Value Pathways (MVPs) are a subset of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning in the 2023 performance year.
- The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions.

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MIPS Performance Categories

MIPS Performance Categories		
Performance Category Weights	**For Performance Year (PY) 2021:** **Traditional MIPS: Individuals, Groups, Virtual Groups** • Quality: 40% • Cost: 20% • Promoting Interoperability: 25% • Improvement Activities: 15% **Traditional MIPS: APM Entities*** • Quality: 55% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 15% ***Note:** We've issued a clarification about PY 2021 performance category weights for APM Entities in this proposed rule. **APM Performance Pathway (APP): Individuals, Groups, APM Entities** • Quality: 50% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 20%	**We are statutorily required to weight the cost and quality performance categories equally beginning with Performance Year (PY) 2022:** **Traditional MIPS: Individuals, Groups, Virtual Groups** • Quality: **30%** • Cost: **30%** • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change) **Traditional MIPS: APM Entities (no change)** • Quality: 55% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 15% **APP: Individuals, Groups, APM Entities (no change)** • Quality: 50% • Cost: 0% • Promoting Interoperability: 30% • Improvement Activities: 20% **Note:** The APP has different scoring weights to APM Entities participating in traditional MIPS.

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- CMS is also required by law beginning in 2022 to set the MIPS performance threshold to either the mean or median of the final scores for all MIPS eligible clinicians for a prior period.
- CMS is using the mean final score from the 2017 performance year/2019 MIPS payment year, which will result in:
  - ✓ The 2022 performance threshold is set at 75 points.
  - ✓ An additional performance threshold is set at 89 points for exceptional performance, which is the 25th percentile of actual 2017 final scores above 75 points.

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Photodocumentation of cecal intubation (QID425)

- CMS is removing this measure from claims-based reporting, indicating it has reached the end of its topped-out lifecycle.
- The measure will still be available as a Clinical Quality Measure (CQM) (i.e., reporting via qualified registry and qualified clinical data registry) as benchmarking data continues to show a gap in performance among providers reporting the measure via this collection type.
- This change could impact small GI practices which choose to report quality measures via claims.

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The 2022 ICD-10-CM Update includes

- 159 New Codes
- 20 Revised Codes
- 32 Invalid/Deleted Codes

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Chapter 11 Diseases of the Digestive System

New K Codes

(K00- K95)

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Important ICD-10-CM Updates

- 13 new ICD-10-CM K- codes for diseases of the digestive system, including a new subcategory, gastric intestinal metaplasia (K31.A-).

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- **K11.8 Other diseases of salivary glands**
  - **Revise Excludes 1:**
    - **From:** sicca syndrome [Sjögren] (M35.0-)
    - **To:** Sjögren syndrome (M35.0-)

- **K22.8 Other specified diseases of esophagus**
  - **Delete Inclusion Term:**
    - Hemorrhage of esophagus NOS

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- **K22.8 Other specified diseases of esophagus – 3 new codes**
  - ***NEW* - K22.81 Esophageal polyp**
    - **Excludes 1:**
      - Benign neoplasm of esophagus (D13.0)
- ***NEW* - K22.82 Esophagogastric junction polyp**
  - **Excludes 1:**
    - Benign neoplasm of stomach (D13.1)
- ***NEW* - K22.89 Other specified disease of esophagus**
  - **Inclusion Term:**
    - Hemorrhage of esophagus NOS

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- ***NEW*** - **K31.A Gastric intestinal metaplasia**

- ***NEW*** - **K31.A0 Gastric intestinal metaplasia, unspecified**
  - **Inclusion Terms:**
    - Gastric intestinal metaplasia indefinite for dysplasia
    - Gastric intestinal metaplasia NOS

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NEW - **K31.A1 Gastric intestinal metaplasia without dysplasia**

- ***NEW*** - **K31.A11** Gastric intestinal metaplasia without dysplasia, involving the ***antrum***
- ***NEW*** - **K31.A15** Gastric intestinal metaplasia without dysplasia, involving ***multiple sites***
- ***NEW*** - **K31.A19** Gastric intestinal metaplasia without dysplasia, ***unspecified site***

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- ***NEW* - K31.A1 Gastric intestinal metaplasia**
  - ***NEW* - K31.A2** Gastric intestinal metaplasia ***with*** dysplasia
    - ***NEW* - K31.A22** Gastric intestinal metaplasia **with high grade** dysplasia
    - ***NEW* - K31.A29** Gastric intestinal metaplasia with dysplasia, **unspecified**
- **K52.2 Allergic and dietetic gastroenteritis and colitis**
  - **Delete Excludes 2:**
  - food protein-induced proctocolitis (K52.82)

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- **K52.29 Other allergic and dietetic gastroenteritis and colitis**
  - **Add Inclusion Terms:**
    - Allergic proctocolitis
    - Food-induced eosinophilic proctocolitis
    - Food protein-induced proctocolitis
    - Milk protein-induced proctocolitis
- **K52.82 Eosinophilic colitis**
  - **Delete Inclusion Terms:**
    - Allergic proctocolitis
    - Food-induced eosinophilic proctocolitis
    - Food protein-induced proctocolitis
    - Milk protein-induced proctocolitis

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❑ **K52.82 Eosinophilic colitis - continued**
- **Add Excludes 2:**
  - Allergic proctocolitis (K52.29)
  - Food-induced eosinophilic proctocolitis (K52.29)
  - food protein-induced enterocolitis syndrome (FPIES) (K52.21)
  - Food protein-induced proctocolitis (K52.29)
  - Milk protein-induced proctocolitis (K52.29)

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❑ **K72.1 Chronic hepatic failure**
- **Add Inclusion Term:**
  - End stage liver disease

❑ **K77 Liver disorders in diseases classified elsewhere**
- **Add Code first:**
  - infectious mononucleosis with liver disease (B27.0-B27.9 with .9)
- **Delete Excludes 1:**
  - infectious mononucleosis with liver disease (B27.0-B27.9 with .9)

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ICD 10 Documentation Tips: Gastroenterology Diagnoses

Diagnosis	Documentation Tips		
Barrett's Esophagus*	**Document when present:** -Low grade dysplasia -High grade dysplasia		
GERD	Mention gastro-esophageal reflux disease with or without associated esophagitis.		
Gastritis	Clarify the acuity (Acute, chronic); Erosive gastritis is categorized under acute gastritis in ICD 10	Provide the type of gastritis (e.g. alcoholic, superficial, atrophic etc.). List any associated alcoholic abuse or dependence.	Differentiate between gastritis, duodenitis and gastroduodenitis Mention any associated medication or drug and the purpose of its use
Gastroenteritis	**Document etiology when known or suspected:** -Infectious -Non-infectious	**If infectious, document organism when known or suspected**	**If non-infectious, document cause, such as:** -Radiation or drug induced, specify drug when known -Allergic or food hypersensitivity, specify food when known
Irritable bowel syndrome*	**Document association with diarrhea:** - With diarrhea - Without diarrhea		
Crohn's Disease*	**Document any associated complications, such as:** -Rectal bleeding, Intestinal obstruction, Fistula, Abscess	**Document anatomical site:** -Large intestine, Small intestine for CD and Pancolitis, Proctitis, Rectosigmoiditis for UC	
Peptic Ulcer	**Document specific site:** -Duodenum, Esophagus, Gastric -Gastro-duodenal, Gastro-jejunal	**Document acuity of peptic ulcer:** -Acute -Chronic	**Document any associated complications, such as:** -Perforation, Hemorrhage
Cholecystitis with cholelithiasis	-Mention the acuity (acute, chronic) -Any associated conditions (Cholangitis)	Detail if biliary obstructions are present Identify when calculi are present	Location of the calculi (gallbladder, bile duct etc.)

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ICD-10 Documentation Tips: Gastroenterology Diagnosis

Diagnosis	Documentation Tips		
Neoplasms	**Document specific site, for example:** -Cardio-esophageal junction -Fundus or body of stomach -Pyloric antrum or pylorus	**Differentiate between primary and secondary (metastatic) site**	**For secondary sites:** -Document primary site and if it is still present
Hepatic Failure/ Hepatic Encephalopathy **Hepatitis**	**Document:** -Acute/subacute -Chronic -If with hepatic coma	**Document etiology, for example:** -Due to alcohol or drugs	**If your intended or suspected diagnosis is hepatic failure/encephalopathy, document it in addition to signs or symptoms, such as confusion, altered levels of consciousness, or coma.**
Gastrointestinal Bleed	**Document etiology and show cause and effect, for example:** -Acute GI bleed due to bleeding esophageal varices	Clarify site of bleed	
Pancreatitis	**Document acute versus chronic**	**Document etiology and show cause and effect, for example:** -Idiopathic acute pancreatitis -Alcohol induced acute pancreatitis	
Diverticulitis*	**Document anatomical site:** - Small Intestine - Large Intestine	**Document associated complication:** -Abscess, perforation, peritonitis -Bleeding	Differentiate between diverticulosis and diverticulitis
Hemorrhoids*	**Use current terminology to describe hemorrhoids:** -First degree or grade/stage 1 -Second degree or grade/stage 2 -Third degree or grade/stage 3 -Fourth degree or grade/stage 4	**If bleeding is present, clearly document in your notes as due to hemorrhoids or due to some other problem**	

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CPT Updates

Digestive System
40490 – 49999

2 Added codes
2 Deleted Codes

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Digestive System – New Codes

- 42975 Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic
- 43497 Lower esophageal myotomy, transoral (i.e., peroral endoscopic myotomy

Code Addition Rationale:

In the 2021 code set, drug-induced sleep endoscopy was reported with codes 31575, 31622 or 92502. These codes, or a combination of the codes did not accurately capture the work involved to perform the procedures while under anesthesia, and they did not reflect the effects of positional head and neck manipulation on the obstruction. Adding 42975 provides the additional information.

CPT 43497 was established to capture transoral lower esophagus myotomy. Prior to 2022 there was not a CPT code to report this procedure

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Digestive System – Deleted Codes

~~43850 Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy~~
~~43855 with vagotomy~~

Rationale:

These codes have been removed due to low utilization.
A parenthetical note has been added in the CPT codebook to indicate these deletions

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GI

Top 10 GI Codes

CPT Code	Description	2022 Non-Facility Payment	% Change	2022 Facility Payment	% Change	2022 HOPD Payment	% Change	2022 ASC Payment	% Change
43235	Uppr gi endoscopy, diagnosis	$305.41	-2%	$120.62	-3%	$826.39	2%	$419.08	2%
43239	Upper GI endoscopy, biopsy	$390.75	-3%	$135.74	-3%	$826.39	2%	$419.08	2%
43246	Place gastrostomy tube	NA	NA	$197.22	-3%	$1,658.81	2%	$706.87	2%
43248	Uppr gi endoscopy/guide wire	$427.03	-1%	$162.95	-3%	$826.39	2%	$419.08	2%
43249	Esoph endoscopy, dilation	$1,146.04	-5%	$150.86	-3%	$1,658.81	2%	$706.87	2%
45378	Diagnostic colonoscopy	$346.73	-3%	$181.43	-4%	$810.48	2%	$411.01	2%
45380	Colonoscopy and biopsy	$446.86	-3%	$196.89	-4%	$1,059.06	2%	$537.08	2%
45381	Colonoscopy, submucous inj	$455.93	-2%	$196.89	-4%	$1,059.06	2%	$537.08	2%
45384	Lesion remove colonoscopy	$502.97	-3%	$225.11	-3%	$1,059.06	2%	$537.08	2%
45385	Lesion removal colonoscopy	$464.66	-3%	$250.31	-3%	$1,059.06	2%	$537.08	2%

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Medical Necessity: Diagnostic Endoscopy

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Medical Necessity

- Medical necessity is the key to success. If medical necessity is not demonstrated, payers can deny a claim, deny authorization for a lab test and/or a diagnostic study, or recoup previously paid claims.
- Medicare and commercial payers will often have local coverage determinations (LCDs) for procedures and testing that include indications and restrictions along with approved diagnosis codes.

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Upper abdominal signs or symptoms:

- Gastroesophageal reflux symptoms that persist or recur following an appropriate trial of therapy for 2 months or more; or
- Persistent vomiting of unknown cause; or
- New-onset dyspepsia in individuals 50 years of age of older; or
- Unexplained dysphagia or odynophagia; or
- Signs or symptoms suggesting structural disease of the upper gastrointestinal tract such as anorexia, weight loss, early satiety, or persistent nausea; or
- Postoperative bariatric surgery with persistent abdominal pain, nausea, or vomiting despite counseling and behavior modification related to diet adherence; or
- Recent or active gastrointestinal bleed; or

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- Unexplained anemia due to either blood loss or malabsorption from a mucosal process;
- For confirmation and specific histologic diagnosis of radiologically demonstrated lesions, including, but not limited to:
  - Suspected neoplastic lesion; **or**
  - Gastric or esophageal ulcer; **or**
  - Upper tract stricture or obstruction; **or**
- Documentation of esophageal varices in individuals with suspected portal hypertension or cirrhosis; **or**
- To assess acute injury after caustic ingestion; **or**
- To identify upper gastrointestinal etiology of lower gastrointestinal symptoms, such as diarrhea, in individuals suspected of having small-bowel disease (for example, celiac disease); or
- To evaluate persons with radiographic findings suggestive of achalasia.

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Other Scenarios, 'not medically necessary

Not medically necessary (third-party payer definition)

- Screening of *any* of the following:
  - Asymptomatic upper gastrointestinal tract of an average risk individual; or
  - Follow-up screening for Barrett's esophagus after a prior EGD screening examination was negative for Barrett's esophagus; or
  - Aerodigestive cancer; or
- Surveillance for *any* of the following:
  - Healed benign disease (for example, esophagitis, gastric or duodenal ulcer); or
  - Gastric atrophy; or
  - Pernicious anemia; or
  - Fundic gland or hyperplastic polyps; or
  - Gastric intestinal metaplasia; or
  - Previous gastric operations for benign disease; or
  - Achalasia; or

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Other Scenarios, 'not medically necessary'

- Radiographic findings of *any* of the following:
  - Asymptomatic or uncomplicated sliding hiatal hernia; or
  - Uncomplicated duodenal ulcer that has responded to therapy; or
  - Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy; or
- Confirming Helicobacter pylori eradication
- Prior to bariatric or non-gastroesophageal surgery in asymptomatic individuals; or
- Metastatic adenocarcinoma of unknown primary site when the results will not alter management; or
- Obtaining tissue samples from endoscopically normal tissue to diagnose GERD or exclude Barrett's esophagus in adults; or
- Symptoms that are considered functional in origin

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Endoscopic Billing Tips

- EGD with biopsy is bundled into any esophageal dilation code unless the biopsy is outside of the area of dilation. Providers need to specify the exact location that was biopsied. If balloon dilation was done, then the biopsy must be a separate area of the esophagus. If Savary (guidewire) dilation was done, then the biopsy would be in the stomach and/or esophagus.
- Biopsy is also bundled into several ERCP codes such as sphincterotomy, stent placement and dilation. Be specific as to site if separate. Make sure to document the instrument used for biopsy and not just say biopsy/random biopsies were done. Example: **Cold forceps biopsies**.
- EMR: The term endoscopic mucosal resection should be used when billing for an EMR with a description of the procedure. The claim for the EMR is often pended by the payer to verify documentation of the EMR.
- Incidental dilation (dragging the balloon) is considered part of an ERCP done to remove stones, sludge, and debris, make sure to document the location of the strictured/narrowed area and method used to dilate.

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Endoscopy Report

- Facility name, patient information
- Date of procedure
- Procedure name (include all techniques performed)
- Preoperative Diagnosis/Indications:
  - Starts medical necessity for the procedure
  - Any personal history of polyps should include previous types of polyp found
  - Any family history of polyps or cancer should include who in the family and at what age (if known)
  - Diagnostic indications must be specific and medically necessary

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Endoscopy Report

- Procedure description:
  - Where is the entry point (mouth, anus, stoma, etc.)?
  - Where is the end point (stomach, duodenum, cecum, transverse colon, etc)?
  - What instrument(s) was/were used?
  - Was/Were the location(s) of lesion(s)/disease(s) documented?
- Postoperative diagnosis or findings
- Recommendations on follow-up (can be pending pathology)
- Procedure note must be signed.

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US Preventative Service Task Force Update

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U.S. Preventive Services Task Force Issues Final Recommendation Statement

- WASHINGTON, D.C. – May 18, 2021– The U.S. Preventive Services Task Force (Task Force) today posted a final recommendation statement on screening for colorectal cancer.
- **Screen all adults aged 45 to 75 years** for colorectal cancer. Several recommended screening tests are available. Clinicians and patients may consider a variety of factors in deciding which test may be best for each person. For example, the tests require different frequencies of screening, location of screening (home or office), methods of screening (stool-based or direct visualization), preprocedure bowel preparation, anesthesia or sedation during the test, and follow-up procedures for abnormal findings. Grade A includes adults aged 50-75, Grade B includes adults aged 45-49 and Grade C includes adults aged 76-85. Look for payer policies to address all grades for coverage.
- Recommended screening strategies include:
  - High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year
  - Stool DNA-FIT every 1 to 3 years
  - Computed tomography colonography every 5 years
  - Flexible sigmoidoscopy every 5 years
  - Flexible sigmoidoscopy every 10 years + annual FIT
  - Colonoscopy screening every 10 years
- **Selectively screen adults aged 76 to 85 years** for colorectal cancer.
- Discuss together with patients the decision to screen, taking into consideration the patient's overall health status (life expectancy, comorbid conditions), prior screening history, and preferences.
- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#fullrecommendationstart

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Medicare Screening Colonoscopy Loophole

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Medicare Screening Colonoscopy Loophole

- The Removing Barriers to Colorectal Cancer Screening Act of 2020 passed the U.S. House Dec. 9 and was included in the COVID-19 relief bill the Senate cleared Dec. 21 and was signed into law on December 27, 2020.
- This closes a loophole for when a screening colonoscopy becomes a diagnostic procedure.
- Currently, Medicare beneficiaries can receive a fully-covered screening colonoscopy, but if polyps are discovered during the screening the beneficiary is charged to test them. The costs of the diagnostic colonoscopy act as a deterrent to screening.

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Medicare Screening Colonoscopy Loophole

- The phase-out of cost-sharing begins in 2023 and goes as follows.
  - 2022: CMS 80%/Patient 20%
  - 2023-2026: CMS 85%/Patient 15%
  - 2027-2029: CMS 90%/Patient 10%
  - 2030 and beyond: CMS pays full 100%
- https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf Page 2175

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GI Modifiers

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Inaccurate Use of Modifiers

- One of the most frequent and common mistakes of Gastroenterology coding is inaccurate modifiers.
- Most of the errors are caused by endoscopic coding mistakes with the confusion caused between modifiers -51 and modifiers -59.
- Generally, modifiers -51 are used for two procedures for two different coding categories that are performed or being done on the same day.
- According to Gastroenterology coding, the American College of Gastroenterology recommends the listing of codes along with its greatest value because of a rule that applies for multiple procedures.
- Whereas modifier -59 is usually utilized for different procedures or different sites which should be addressed on the particular day but not being followed.
- American Gastroenterology Association offers the surgery of hot biopsy polypectomy that's being performed on one lesion while cold biopsy is performed on another lesion.
- The above procedures can be paid by insurance companies with no doubt when modifiers -59 are added during gastroenterology coding.
- Modifiers -51 and -59 are usually confused and result in claim rejections and denials.

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Modifier -22

Modifier -22 Definition: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier -22 to the usual procedure code. Documentation must support the substantial additional work and reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, the severity of patient's condition, physical and mental effort required). Documentation should be simple layman terminology and contained in the operative report. The operative report should be attached to the claim. Payment is usually 20-30% higher but varies by the payer.

Example: Documentation indicates that over 60 minutes was spent controlling bleeding from a duodenal ulcer with at least 4 types of methods utilized to finally control the bleed. The normal time for the procedure is 15 minutes.

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Modifier -25

- Modifier -25 was submitted on a visit done the same day as a procedure.
- A significantly separate visit is billable on the same day as a procedure.
- A quick visit "meet me in endo" is not separately billable.
- Hospital follow-up visits are not billable on the same day as the procedure unless something unrelated to the procedure has been addressed
- Diagnosis order on the claim can be essential in avoiding these denials. Example: submit the symptoms for the consult and findings for the procedure whenever possible.
- Currently reimbursable by Medicare and most payers at 100% of the approved amount but some payers will reimburse at 50 or 75% of the approved amount per contractual agreement.

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Modifier -25 Examples:

- Patient is seen in consultation for rectal bleeding constipation. The provider performs a separate history, exam, and decides the patient would benefit from an in-office anoscopy today to determine the bleeding source. The provider also recommended the patient start Miralax for treatment of constipation.
  - **Consultation is separately billable with modifier 25.**
- Patient is seen in the hospital as an initial visit for evaluation of acute blood loss anemia and possible GI bleeding. The provider performs a separate history, exam and decides the patient should undergo urgent endoscopic evaluation. Procedures will be performed after blood transfusion.
  - **Initial hospital visit is separately billable with modifier -25.**
- Patient is scoped in the hospital to determine the source of hematochezia. Later the same day, GI is re-consulted for evaluation of new epigastric pain.
  - **Follow-up hospital visit is separately billable with modifier -25.**

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Modifier -33

- Preventive Services: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding -33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

- Modifier -33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier -33 will process under the member's medical or preventive benefits, based on the diagnosis and CPT codes submitted.

- For services represented by codes that may be used for either diagnostic, therapeutic or preventive services, modifier 33 must be appended to that code on the claim when the service was used for the preventive indication.

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Modifier -33 Example

- For example, CPT code 45378, colonoscopy, may be performed for the 50-year-old asymptomatic individual as a routine screening for colorectal cancer. In this case, the colonoscopy is performed for preventive screening, and modifier -33 should be appended, in addition to a well-person diagnosis code, such as Z12.11.
- However, a colonoscopy, using this same code, may be performed in response to symptoms that a person exhibits. In that case, this service represents diagnostic colonoscopy. The diagnosis code would be one that would signify the symptoms exhibited and modifier -33 would not be appended.
- When a separately submitted service is inherently preventive, modifier -33 is not used.

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Modifier -PT

- Modifier -PT applies to Medicare products only (Medicare Advantage and Medicare Supplemental). To determine the appropriate use of modifier -PT, it's important to know why the member is presenting for treatment.
- Modifier -PT indicates that a colorectal cancer screening test was converted to a diagnostic test or other procedure (impacts colonoscopy and sigmoidoscopy codes). The appropriate use of modifier -PT will help reduce claim adjustments related to colorectal screenings and your corresponding refunds to members.

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Please see the following scenarios for guidance:

- Screening exam only: In a situation where a member presents for treatment solely for the purpose of a screening exam, without any signs or symptoms of a disease, then such a procedure should be considered a screening.
- The appropriate use of diagnosis codes and screening procedure codes is valuable in promoting appropriate adjudication of the claim.
- The use of the modifier -PT in conjunction with a CPT procedure or HCPCS code that is defined as a screening based on that code's description is not necessary.

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Treatment due to signs or symptoms to rule out or confirm a suspected diagnosis:

- In the instance that a member presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam.

- In such a situation, the modifier -PT should not be used and the sign or symptom should be used to explain the reason for the test.

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- Screening colorectal exam converted to a diagnostic service: In a circumstance where a member presents for a screening exam (without signs or symptoms), and an issue is encountered during that preventive exam, then such a circumstance would warrant the use of the -PT modifier.
- The procedure and diagnosis codes that would typically be used in such an instance may not clearly demonstrate that the service began as a screening procedure, but had to be converted to a diagnostic procedure due to a pathologic finding (e.g., polyp, tumor, bleeding) encountered during that preventive exam.
- The use of the -PT modifier in the instance of a screening colorectal exam being converted to a diagnostic service would clarify that despite the end result the service began as a screening service.

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Modifier -51 and -59

- Correct and appropriate use of modifiers is important to file accurate claims and thus receive correct payments. Modifiers enable surgeons to effectively meet payment policy requirements established by the insurers. Wrong use of modifiers is one of the most common GI coding mistakes.
- Gastroenterology coding and in another specialty coding, when the same surgeon performs multiple procedures in the same operative setting, often there is confusion about using modifier -51 (Multiple procedures) or modifier -59 (Distinct procedural service).

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- Modifiers -51 and -59 are known as surgical modifiers and are both used when multiple services are performed during a single encounter. However, they serve different purposes.
- Modifier -51 can be used to report multiple surgeries performed on the same day, during the same surgical session. It is used to identify the second and subsequent procedures to third-party payers. The modifier would be applied to any secondary procedures performed. It can be used to document two procedures in two different coding categories performed on the same day, just like EGD and colonoscopy.
- To report this modifier right, the coder should list the procedure with the highest RVU (highest paying) first and use modifier -51 on the subsequent service(s) with lower RVU (lowest paying).

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- The American Society of Gastroenterology says that modifier -51 applies to:
  - Different procedures performed at the same session
  - A single procedure performed multiple times at different sites
  - A single procedure performed multiple times at the same site
- It is not to be used when a procedure is performed along with an Evaluation and Management (E/M) service.
- There are instances where multiple procedures are performed but modifier -51 is not appropriate. Modifier -51 is not appended to add-on codes like CPT code 64462.

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In gastroenterology, separate rules are created for upper and lower GI procedures.

- For example, whenever a colonoscopy is performed, it is necessary to determine if the colonoscopy is performed for diagnostic purposes or a therapeutic reason. While coding, medical documentation should be referred to for specific modifier usage cues.
- Medical documentation should indicate the part of the colon till the scope could be advanced.
- Choosing between modifiers -53 and -52 can sometimes be confusing.
- A wrong modifier can lead to denials. The reason for this confusion is the ambiguity in its definitions.

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Modifier -52

- Modifier -52 indicates a reduced service not a discontinued/incomplete procedure.
- Example:
  - Colonoscopy to the ascending colon with biopsy of an obstructing lesion in the ascending colon.
  - Instructions per CPT recommend that if unable to get to the cecum/terminal ileum during a therapeutic/surgical procedure, add modifier -52 to the claim to support a reduced service
  - Payment may be subject to review of the endoscopy report as most payers will tend to review either modifier -52 or modifier -53.
- Should also be used on a planned EGD when the scope does not get beyond the gastric outlet and there is no plan to repeat the procedure.

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Modifier -52 Example

The use of modifiers -52 or -53 is based on scheduling a repeat EGD. Refer to the chart for using modifiers during EGD.

Next Services

Endoscopy	Duodenum examined	Repeat examination	Modifier
EGD	No	Planned	53
EGD	No	Not planned	52

Using wrong modifiers leads to underpayments and in many cases, claim denials. You can avoid problems with your claims by referring to these coding guidelines and paying closer attention to specific case scenarios.

https://www.nextservices.com/choosing-between-modifier-53-and-52-gastroenterology-example/

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Modifier -53

- Modifier -53 indicates the physician elected to terminate the procedure due to the patient's well-being.
  - CMS instructs to use the -53 modifier when the scope does not go to cecum but goes beyond the splenic flexure and the intent of the procedure is a screening or diagnostic colonoscopy
  - Set fee for colonoscopy with -53 modifier in the Medicare fee schedule. (50% of the approved colonoscopy fee) Fee not automatically set in non- Medicare fee schedule and is subject to review prior to payment.
  - Usually due to a poor prep or patient condition.
  - If unable to get past the splenic flexure, only sigmoidoscopy can be billed.
- Should also be used on an intended EGD that did not get beyond the gastric outlet and the patient will be brought back at a later time for a complete examination.

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Modifier -53 Example 1

Indication: Hematochezia

Post-Endoscopy Findings: Normal colonoscopy to the ascending colon. Poor prep proximal to that area. Recommend re-evaluation in 2 months.

Procedure: Colonoscopy with limited view proximal to the ascending colon.

CPT Code:

45378 Diagnostic colonoscopy to the cecum and/or small intestine/colonic anastomosis

Add modifier 53 to indicate incomplete procedure.

Diagnosis Code:

K92.1 Hematochezia

Z53.8 Procedure and treatment not carried out for other reasons

(utilize your comment field (box 19) of the HCFA 1500 to let the payer know where the scope ended and why)

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Modifier -53 Example 2

Indication: Average risk colon screening

Post-endoscopy Findings: Poor prep. Stool in the rectal vault. Scope not advanced beyond the rectum. Screening could not be completed. Reschedule with two-day prep.

Procedure Code:

G0104 Average risk screening sigmoidoscopy with modifier 53

Or (for those payers not accepting G0104)

45330-33-53: Diagnostic sigmoidoscopy with modifier 33 indicating this is a preventive service.

Diagnosis Code:

Z12.11 Encounter for screening for malignant neoplasm of colon

Z53.8 Procedure and treatment not carried out for other reasons

(utilize your comment field (box 19) of the HCFA 1500 to let the payer know where the scope ended and why)

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Next Services

Type of colonoscopy	Organs viewed/operated	Splenic flexure	Bill procedure as	CPT code	Modifier
Diagnostic	Rectum, sigmoid colon, descending colon	Not crossed	Flexible Sigmoidoscopy	45330	No
Diagnostic	Rectum, sigmoid colon, descending colon and beyond but not upto Cecum	Crossed	Colonoscopy	45378	53
Diagnostic	Rectum, sigmoid colon, descending colon, transverse colon, ascending colon, Cecum	Crossed	Colonoscopy	45378	No
Therapeutic	Rectum, sigmoid colon, descending colon	Not crossed	Flexible Sigmoidoscopy	45331 -45347	No
Therapeutic	Rectum, sigmoid colon, descending colon and beyond not upto Cecum	Crossed	Colonoscopy	45379 - 45398	52
Therapeutic	Rectum, sigmoid colon, descending colon and beyond but not upto Cecum	Crossed	Colonoscopy	45379 – 45398	No

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Modifier -59

Modifier -59 Definition: “Distinct Procedural Service.”

- Modifier -59 is one of the most used modifiers. You should only use modifier -59 if you do not have a more appropriate modifier to describe the relationship between two procedure codes. Modifier -59 identifies procedures/services that are not normally reported together.
- Modifier -59 is used if the same doctor or qualified healthcare professional performed an unrelated procedure on the same patient on the same day the doctor performed the office visit.

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Modifier -59 Example

- Never attach modifier -59 to an E/M service. Depending on the local policy, if the tests are necessary due to two separately identifiable conditions, you may be able to link the appropriate diagnosis code to each CPT® code and add modifier -59 to the second procedure. To report a separate and distinct E/M service with a non-E/M service performed on the same date, check to see if modifier -25 is appropriate.
- CMS uses four **sub-modifiers** that replace modifier -59:
  - **Modifier XE** – "Separate Encounter: A service that is distinct because it occurred during a separate encounter." Only use this to describe separate encounters on the same date of service.
  - **Modifier XS** – "Separate Structure: A service that is distinct because it was performed on a separate organ/structure."
  - **Modifier XP** – "Separate Practitioner: A service that is distinct because it was performed by a different practitioner."
  - **Modifier XU** – "Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service."

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Modifier -79

Modifier -79 Definition: "Unrelated procedure or service during a postoperative period."

- Modifier -79 is used for unrelated procedures provided by the same physician or other qualified health care professional during the postoperative period.
- For example, a physician performs exploratory surgery on a lump discovered in a patient's forearm. The lump turns out to be a benign cyst. Within the post-op period, the same patient returns to have a fibroma removed by the same physician. The two incidents are unrelated, so modifier -79 is used.
- It's not uncommon to get postoperative claims paid incorrectly or not at all, especially when the surgery of a second procedure takes place during the global period for the surgery that was performed first. When you use modifier -79 correctly, this allows the claim for the second surgery to be paid. Remember, each surgery's global period (postoperative) runs independently of the other.
- Never apply modifier -79 to office visits (see modifier -24) and only append to other unrelated surgery or procedures with a 90-day global period.

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Coding Surgical Procedures

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Visit Prior to Screening Colonoscopy

- Most major commercial payers will be for the visit prior to screening (average risk) as long as the plan is under the Affordable Care Act.
- There is a code S0285 to bill which was specifically created for the consultation
  prior to screening colonoscopy. Approved dx for this code is Z12.11 (average risk screening), Z80.0 (family history of colon cancer), and Z83.71 (family history of colon polyps) only.
- If there are other symptoms addressed then you would bill a standard visit code (99202-99205) or (99212-99215) depending upon if the patient is new or established with the practice.
  - *Clinical Example:* Patient presents for consultation prior to screening colonoscopy. Upon gathering a history from the patient, there is mention of trouble with constipation. The provider completes a history and exam and instructs the patient to try Miralax and to increase water and fiber intake. The provider documented "the patient's constipation does
    not warrant diagnostic colonoscopy, however, the patient is 50 and due for screening colonoscopy, which will be scheduled.
  - Visit is billed based upon addressing constipation and procedure is ordered and documented as a screening colonoscopy.

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Visit Prior to Screening Colonoscopy

- Medicare does not cover the visit prior to screening or surveillance colonoscopy and considers this visit part of the pre-workup associated with the procedure.
- The only time you can bill the visit to Medicare is when you addressed something completely unrelated. That problem would be billed as the primary diagnosis and the level of service should be based upon the decision-making for that encounter.

Evaluation & Management with Screening Colonoscopy by CMS:

- The patient may be at high-risk for the screening procedure due to other conditions (i.e., COPD, medications, etc.) that affect the pre-operative instructions given to the patient or how the procedure is performed, however, the consideration given to these risk factors is inclusive in the usual "pre-operative" work associated with the procedure. Reporting an E/M service with a diagnosis code associated with one of the patient's risk factors implies that the GI physician saw the patient in order to diagnose or manage the illness identified and that is not the case. The GI physician is seeing the patient in order to determine the suitability of the patient for the screening procedure and CMS has stated that these visits are not billable.

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ICD-10 Coding Tips

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Document and Code for Medical Necessity

- Many practices are seeing an increase in claim denials/rejections by many payers which include:
  - ❖ Invalid ICD-10 code
  - ❖ Non-specific ICD-10 code or “lacks specificity”
  - ❖ Lack of medical necessity
- Be sure and keep up-to-date on payer policies for medical necessity and specific ICD-10 changes/revisions
- Monitor “medical necessity” denials closely:
  - ❖ Track the specific reason for the denial as well as the clinician, and payer
  - ❖ Communicate the information with ALL clinical staff, coding, and billing teams
  - ❖ Conduct documentation and coding education based upon these denials
  - ❖ Audit for overall improvement and compare denial rates

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Document and Code for Medical Necessity

A patient with a history of Crohn’s large intestine presents with rectal bleeding, LLQ abdominal pain, and diarrhea.

- K50.111 Crohn’s Disease large intestine with rectal bleeding
- K50.118 Crohn’s Disease large intestine with other complications
  - R10.32 LLQ Abdominal Pain
  - R19.7 Diarrhea
- Per ICD-10 CM instructions: When the combination code lacks the necessary specificity in describing the manifestation or complication, an additional code should be used as the secondary code.
- Be sure the provider is specific as to a true “flare” or a true “complication” so the correct codes are assigned.

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Document and Code for Medical Necessity (1-3)

- Patient with Ulcerative Pancolitis, currently stable without flare, presents for her 6-week Remicade Infusion.
  - K51.00 Ulcerative Pancolitis without complications
- Payers are starting to deny infusion claims for medical necessity when billed with the non-specific IBD diagnosis codes.
- Be sure and educated ALL providers and staff regarding this issue to ensure the most specific IBD code is assigned to these claims.

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Document and Code for Medical Necessity (2-3)

- Patient with a long-standing history of GERD who presents for upper endoscopy due to persistent heartburn and epigastric pain despite a 3-month trial of PPI therapy.
  - Diagnosis: R12 – Heartburn
  - Diagnosis: R10.13 – Epigastric pain
  - Diagnosis: K21.9 – GERD
- GERD alone will not support the need for a diagnostic upper endoscopy. There should be documentation to support that the patient is still symptomatic despite 2+ months of PPI therapy.

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Document and Code for Medical Necessity (3-3)

- Patient presents for follow-up of rectal bleeding and pain. Rectal exam confirmed grade II internal hemorrhoids. The patient has tried topical creams which has not helped with the ongoing bleeding and pain. Recommend patient now undergo banding ligation procedure. Risks and benefits were discussed with the patient who agree to proceed.
  - Diagnosis: K64.1 – stage/grade II hemorrhoids (K64._ codes include bleeding)
  - Diagnosis: K62.89 – other specified disease of rectum (includes pain)

- Documentation for hemorrhoid treatments must include any symptoms the patient has related to known hemorrhoids, that medication therapy failed, and risk/benefits were discussed with the patient.

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Conclusion

- Every year the coding updates become more and more specific.
- Therefore, it is necessary to obtain and code the most specific diagnoses and conditions available.
- Be sure to look for new codes with the letter A in the digits
- Of course, always code to physician documentation unless otherwise specified
- Follow the Coding Guidelines!
  - Don’t code from memory as each year there are many guideline revisions
  - And combinations of diagnoses change the codes and sequencing in many situations!

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Resources

- https://gastro.org/news/2022-proposed-medicare-payment-policies-released/
- http://www.roadto10.org
- https://www.mdedge.com/gihepnews/article/197833/gastroenterology-billing-and-coding-just-basics/page/0/1
- https://www.outsourcestrategies.com/blog/gastroenterology-billing-coding-2021-key-points-to-note.html
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764TextOnly.pdf
- https://codingintel.com/coding-for-screening-colonoscopy/
- https://www.bostonscientific.com/en-US/reimbursement/gastroenterology.html
- https://whatismedicalinsurancebilling.org/2021/02/modifier-33-preventive-services-usage.html

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