

# 2012 CPT® CODING UPDATES

## Gastroenterology CPT Advisors

Joel V. Brill, MD, AGA CPT Advisor

Daniel C. DeMarco, MD, ACG CPT Advisor

Glenn D. Littenberg, MD, ASGE CPT Advisor



The AGA, ACG and ASGE work closely together to ensure that adequate methods are in place for gastroenterology practices to report and obtain fair and reasonable reimbursement for procedures, tests and visits. The society advisors continuously review Current Procedural Terminology® (CPT®) and work through the AMA process to revise and add new codes as appropriate.

## **Table of Contents:**

<b>New/Deleted CPT Codes for Abdominal Paracentesis and Peritoneal Lavage</b> .....	<b>3</b>
<b>CPT Code Revisions</b> .....	<b>4</b>
<b>New PQRS Measures for 2012</b> .....	<b>7</b>
<b>New ICD-9 Codes and Preparation for ICD-10</b> .....	<b>8</b>
<b>Understanding the RUC Survey Process</b> .....	<b>10</b>
<b>Common GI Billing and Coding Questions</b> .....	<b>12</b>
<b>Medicare E-Prescribing Incentives</b> .....	<b>14</b>

# New/Deleted CPT Codes for Abdominal Paracentesis and Peritoneal Lavage

For 2012, three new CPT codes for abdominal paracentesis and peritoneal lavage have been created. These replace codes 49080 and 49081, abdominal paracentesis, initial and subsequent procedures, respectively.

The new codes for abdominal paracentesis, 49082 and 49083, describe the procedure performed without or with imaging guidance. If the health-care professional performs abdominal paracentesis without imaging guidance, code 49082, *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance*. If abdominal paracentesis is performed with imaging guidance (regardless of the method used), code 49083, *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance*.

Code 49084, *Peritoneal lavage, including imaging guidance, when performed* is used to describe the procedure where a vertical skin incision is made, the linea alba is divided and the peritoneum entered after it has been picked up to prevent bowel perforation. A catheter is inserted towards the pelvis and aspiration of material is attempted using a syringe. If no blood is aspirated, warm saline is infused and after a few minutes, the effluent is drained and sent for analysis.

Parentheticals are included with codes 49083 and 49084 instructing the provider not to report these codes with separate imaging codes, including ultrasonic guidance code 76942, fluoroscopic guidance code 77002, computed tomography guidance code 77012, and/or magnetic resonance guidance code 77021.

## Surgery / Digestive System

### Abdomen, Peritoneum and Omentum

#### Incision

<b>49080</b>	Peritoneocentesis, abdominal paracentesis or peritoneal lavage- (diagnostic or therapeutic); initial
<b>49081</b>	subsequent
▶ (49080, 49081 have been deleted. To report, see 49082, 49083, 49084) ◀	
(if imaging guidance is performed, see 76942, 77012)	
• <b>49082</b>	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
• <b>49083</b>	with imaging guidance
▶ (Do not report 49083 in conjunction with 76942, 77002, 77012, 77021) ◀	
• <b>49084</b>	Peritoneal lavage, including imaging guidance, when performed
▶ (Do not report 49084 in conjunction with 76942, 77002, 77012, 77021) ◀	

# CPT Code Revisions

## Initial Observation Care

Time components have been added to descriptors of the initial observation care codes:

**99218:** Physicians typically spend **30 minutes** at the bedside and on the patient's hospital floor or unit.

**99219:** Physicians typically spend **50 minutes** at the bedside and on the patient's hospital floor or unit.

**99220:** Physicians typically spend **70 minutes** at the bedside and on the patient's hospital floor or unit.

## Prolonged Services

For prolonged services codes 99354–99357, the term “physician” was removed from the descriptors to enable other health-care providers to report these codes when appropriate.

The term “face-to-face” was also removed from the descriptor and now simply reads, “... requiring direct patient contact ...”

Code 99356 now includes the observation setting in the descriptor and can be reported in addition to an observation care code.

## Esophageal Motility

A revision was made to codes 91010 and 91013, and codes 0240T and 0241T to identify the intent for use of these codes to report two-dimensional or three-dimensional esophageal manometry studies performed without pressure topography. Clarifications note that code 91013 should be used “in conjunction with code 91010” to report esophageal motility studies with stimulant or perfusion.

The appropriate method of reporting esophageal motility studies with high-resolution esophageal pressure topography is by using code 0240T and additionally reporting code 0241T when stimulant or perfusion are used.

## Modifier 33

When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. 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.

In response to the Patient Protection and Affordable Care Act, which requires all health-care plans to begin covering immunizations and preventive services without any cost sharing, modifier 33 has been added to identify a service as a preventive service. The modifier allows providers to identify to payors that the service was preventive under applicable laws and patient cost sharing does not apply.

Modifier 33 is **not** to be used for Medicare patients with screening colonoscopies converted to diagnostic/therapeutic colonoscopies. For Medicare beneficiaries, the PT modifier is used for this purpose.

## Category II Codes

Code 3125F, *esophageal biopsy report with statement about dysplasia (present, absent or indefinite)*, is used within the pathology measure set. The measure notes whether an esophageal biopsy report that documents the presence of Barrett's mucosa includes a statement about dysplasia.

### Performance Measurement Codes for IBD Quality Measures:

<b>1036F</b>	Current tobacco non-user (CAD, CAP, COPD, PV) (DM) (IBD)
<b>1052F</b>	Type, anatomic location and activity all assessed (IBD)
<b>3095F</b>	Dual-energy X-ray absorptiometry (DXA) results documented (OP) (IBD)
<b>3096F</b>	Central dual-energy X-ray absorptiometry (DXA) ordered (OP) (IBD)
<b>3216F</b>	Patient has documented immunity to hepatitis B (hep C) (IBD)
<b>3510F</b>	Documentation that tuberculosis (TB) screening test performed and results interpreted (HIV), (IBD)
<b>3517F</b>	Hepatitis B virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-tumor necrosis factor (TNF) therapy (IBD)
<b>3520F</b>	<i>Clostridium difficile</i> testing performed (IBD)
<b>3750F</b>	Patient not receiving dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days (IBD)
<b>4005F</b>	Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed (OP) (IBD)
<b>4035F</b>	Influenza immunization recommended (COPD) (IBD)
<b>4037F</b>	Influenza immunization administered or previously received (COPD, PV, CKD, ESRD)(IBD)
<b>4040F</b>	Pneumococcal vaccine administered or previously received (COPD) (IBD) (PV)
<b>4069F</b>	Venous thromboembolism (VTE) prophylaxis received (IBD)
<b>4142F</b>	Corticosteroid-sparing therapy prescribed (IBD)
<b>4149F</b>	HBV injection administered or previously received (hep C, HIV) (IBD)
<b>6150F</b>	Patient not receiving a first course of anti-TNF therapy (IBD)

## Qualified Health-Care Professional

A “physician or other qualified health-care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable), and who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified health-care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

Language has been added to the “Instructions for Use of the CPT Codebook” defining “qualified health-care professional.” The revision was necessary to clarify the sections of CPT that include “or other qualified health-care professional” as questions may arise regarding professionals who are qualified and licensed to perform a service, but not independently report that service, and those nonphysician health-care professionals who are able to perform a professional service within their scope of practice and independently report a professional service.

# New PQRS Measures for 2012

The Physician Quality Reporting System (PQRS) includes new measures in the IBD measures group for 2012.

**These measures can only be reported via a registry.**

MEASURE NUMBER	MEASURE TITLE AND DESCRIPTION
269	<p><b>IBD: Type, Anatomic Location and Activity All Documented</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD who have documented the disease type, anatomic location and activity at least once during the reporting period.</p>
270	<p><b>IBD, Preventive Care: Corticosteroid-Sparing Therapy</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD who have been managed by corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days that have been prescribed corticosteroid-sparing therapy in the last reporting year.</p>
271	<p><b>IBD, Preventive Care: Corticosteroid-Related Iatrogenic Injury — Bone Loss Assessment</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days and were assessed for risk of bone loss once per the reporting year.</p>
272	<p><b>IBD, Preventive Care: Influenza Immunization</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD for whom influenza immunization was recommended, administered or previously received during the reporting year.</p>
273	<p><b>IBD, Preventive Care: Pneumococcal Immunization</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD that had pneumococcal vaccination administered or previously received.</p>
274	<p><b>IBD: Testing for Latent TB Before Initiating Anti-TNF Therapy</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD for whom a TB screening was performed and results interpreted within six months prior to receiving a first course of anti-TNF therapy.</p>
275	<p><b>IBD: Assessment of HBV Status Before Initiating Anti-TNF Therapy</b>            Percentage of patients aged 18 years and older with a diagnosis of IBD who had HBV status assessed and results interpreted within one year prior to receiving a first course of anti-TNF therapy.</p>

# New ICD-9 Codes and Preparation for ICD-10

New International Classification of Diseases (ICD-9)-clinical modification (CM) codes for 2012 became effective on Oct. 1, 2011. There are a handful of new codes that may impact gastroenterology:

ICD-9	DESCRIPTOR
041.41	Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC) O157
041.42	Other specified Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC)
041.43	Shiga toxin-producing <i>Escherichia coli</i> [ <i>E. coli</i> ] (STEC), unspecified
041.49	Other and unspecified <i>Escherichia coli</i> [ <i>E. coli</i> ]
539.01	Infection due to gastric band procedure
539.09	Other complications of gastric band procedure
539.81	Infection due to other bariatric procedure
539.89	Other complications of other bariatric procedure
573.5	Hepatopulmonary syndrome
997.41	Retained cholelithiasis following cholecystectomy
997.49	Other digestive system complications
999.42	Anaphylactic reaction due to vaccination
999.49	Anaphylactic reaction due to other serum
999.52	Other serum reaction due to vaccination
999.59	Other serum reaction
V12.29	Personal history of other endocrine, metabolic and immunity disorders
V13.89	Personal history of other specified diseases

## ICD-10 Is Looming

A major change in coding will come on Oct. 1, 2013, when physicians will have to switch to using ICD-10-CM with its three- to seven-digit structure and much greater complexity.

- ICD-10-CM codes will have three to seven digits.
- Digit one is alpha (A–Z, not case sensitive).
- Digit two is numeric.
- Digit three is alpha (not case sensitive) or numeric.
- Digits four to seven are alpha (not case sensitive) or numeric.

Over the next two years, physician practices will need to adapt to the new codes. The GI societies will publish resources for reference as the time for conversion nears. ICD-10-CM files, information and mapping between ICD-10-CM and ICD-9-CM can be found on the [CDC website](#). Read [CMS information about ICD-10](#).

## Here are some steps to get started:

- Visit the CMS website and download materials, including all 2011 ICD-10 codes in text format.
- Order a copy of the ICD-10-CM book available through any coding reference publishers. This will allow you to see the book format, which is quite similar to ICD-9-CM. ICD-10 laminated code sheets are also available at [www.askmuellerconsulting.com](http://www.askmuellerconsulting.com).
- Begin training all providers since non-specific diagnosis codes will be routinely denied by all payors beginning Oct. 1, 2013. The average cost to the practice to process a denied claim is estimated at \$40.
- Coding staff will need to be trained. Plan on sending staff to [training seminars](#) to learn about ICD-10. Plan ahead for a slowdown in coder productivity, which may translate to a slowdown in cash flow. Utilize an ICD-9 to ICD-10 converter, which is available with most coding software publications, including the [AskMueller Coding Advisor](#).

Example of ICD-9 to ICD-10 for Barrett's esophagus:

ICD-9	DESCRIPTOR	ICD-10	DESCRIPTOR
530.85	Barrett's esophagus	K2270	Barrett's esophagus without dysplasia
		K22710	Barrett's esophagus with low-grade dysplasia
		K22711	Barrett's esophagus with high-grade dysplasia
		K22719	Barrett's esophagus with dysplasia, unspecified

## Partial Code Freeze Now in Effect

The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 on Oct. 1, 2013. There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on Oct. 1, 2011.
- On Oct. 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases.
- On Oct. 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On Oct. 1, 2014, regular updates to ICD-10 will begin.

# Understanding the RUC Survey Process

The AMA formed the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to act as an expert panel in developing relative value recommendations to CMS. The AMA established the RUC process in the course of its normal activities and as a basis for exercising its First Amendment right to petition the federal government as part of its research and data collection activities, for monitoring economic trends, and in connection and related to the CPT development process. In addition, CMS is mandated to make appropriate adjustments to the new resource-based relative value scale in response to the Omnibus Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data and procedures. The purpose of the RUC process is to provide recommendations to CMS for use in annual updates to the new Medicare relative value scale. These recommendations are based on data collected from surveys of practicing physicians regarding the time, intensity, and complexity of new and revised CPT codes.

AGA and ASGE are active participants in the RUC. ACG collaborates with AGA and ASGE in the development of recommendations to the RUC. Your participation in this survey process is an opportunity for you to have a direct input on how your work is valued.

## How Medicare Sets Physician Payment Rates

In 1992, Medicare implemented the current cost-based physician fee schedule. For each of the greater than 7,000 services on the fee schedule, a relative value unit (RVU) is assigned based on the time and intensity of physician work, practice expense and cost of professional liability insurance necessary to provide the service. To determine the Medicare fee, a service's RVUs are multiplied by a dollar conversion factor that is updated annually. A geographic adjustment is also made.

## The Basics of the RUC Survey Process

When new codes are established or existing codes are revised by the CPT editorial panel, a survey of physicians providing that service is conducted by the relevant medical specialty society. The surveys are conducted under the auspices of the RUC. AGA and ASGE are active participants in the process by conducting surveys for gastroenterology services, analyzing the results and presenting recommendations to the RUC. The purpose of the survey is to measure physician work involved in performing the procedure to determine an accurate relative value recommendation for the service. The AMA defines physician work as:

- Physician time it takes to perform a service.
- Physician mental effort and judgment.
- Physician technical skill and physical effort.
- Physician psychological stress that occurs when an adverse outcome has serious consequences.

The 29 members of the RUC, composed of representatives from various medical specialty societies, vote on the physician work recommendations submitted by the specialty societies. Societies also submit data on the direct practice expenses associated with the service (supplies, equipment and clinical labor) when provided in the non-facility (e.g., office) setting. In September of each year, the RUC submits its recommendations to CMS. Through the federal regulations process, which is open for public comment, CMS publishes proposed work values in the Medicare physician fee schedule (MPFS) proposed rule. After the public comment process, the new values are finalized in the MPFS final rule and implemented on Jan. 1 of the following year. Historically, the Medicare agency has accepted the majority of RUC recommendations, although this number has declined in recent years.

## The Survey Process Requires Physician Input

For the RUC survey process to succeed, the cooperation and participation of practicing physicians is critical. **It is only with your input that we can provide the RUC and CMS with accurate data** so gastroenterology services can be fairly valued by Medicare. Many private insurers also base their rates on a percentage of Medicare, resulting in a wide and significant impact of this process.

Our societies need **to expand our database of practitioners who are able to complete the work surveys** we use to recommend RVUs for procedures, including both existing codes under review and new codes that may come up in the future. Gastroenterologists who perform routine exams such as colonoscopy and esophagogastroduodenoscopy (EGD) and more complex exams such as endoscopic retrograde cholangiopancreatography are needed. We realize practicing physicians are faced with increasing demands on their time, but we believe this is an important, valuable and unique opportunity for any practicing gastroenterologist. By participating in a RUC survey, you will be able to have direct input on the valuation of the services you provide. **If you are contacted via e-mail to participate in RUC surveys, we urge you to complete them.**

If you would like more information on this process, please contact:

**Adam Borden, MHA**, at AGA

Email: [aborden@gastro.org](mailto:aborden@gastro.org)

Phone: 301-941-2629

**Samuel Reynolds, MS, MBA**, at ASGE

Email: [sreynolds@asge.org](mailto:sreynolds@asge.org)

Phone: 630-570-5643

More information about the RUC is available at: [www.ama-assn.org/go/rbrvs](http://www.ama-assn.org/go/rbrvs).

# Common GI Billing and Coding Questions

KATHLEEN MUELLER, RN, CPC, CCS-P, CMSCS, CCC, PCS

## Evaluation and Management — New Patient Visit Versus Established Patient Visit

Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received, within the past three years, any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice.

An established patient is one who has received professional services, within the past three years, from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice.

### Specialty Versus Subspecialty

- Internal medicine is a specialty.
- Gastroenterology is a subspecialty.
- Infectious disease is a subspecialty.
- Transplant hepatology is a subspecialty.

Unless the gastroenterology practice employs an infectious disease provider and/or transplant hepatologist, the three-year rule applies.

### Examples:

1. A patient was seen in the practice with choledocholithiasis last year by Dr. A. The patient returns in two years with melena and sees Dr. B in the practice. Since it has been less than three years, the patient would be considered an established patient in the practice.
2. A patient is seen today with elevated liver enzymes and a work-up is scheduled. After work-up, the patient is sent to another physician in the group who specializes in endoscopic ultrasound. Even though this is a specific area of expertise, it is not a recognized subspecialty, so this patient would be an established patient to this provider.
3. A patient is seen for direct referral colonoscopy (open access screening) by Dr. A and returns to see Dr. A or another gastroenterologist in the same group two years later for GERD symptoms. Although this is the first evaluation and management service provided by the group, the patient is still an established patient.

## Question and Answer Forum

**Question: Do codes 43239 and 43255 require modifier 59? Which do I bill first, and to which code do I attach the modifier?**

**Answer:** If the primary purpose of the endoscopy was control of bleeding, and a separate lesion/site was found, which required biopsy, then 43255 would be reported first; 43239 with 59 modifier would be reported for the second service, which would otherwise be bundled (i.e., biopsy of the bleeding site would not be separately reportable). If bleeding resulted from biopsy of a lesion and the treatment was for this purpose, the bleeding control would be considered part of the procedure (43239) and thus, 43255 would not be separately reported.

**Question: My physician does an EGD to place the BRAVO capsule. How do I bill for this?**

**Answer:** Please look at the indication and the description on the endoscopy report. If it was done for symptoms and/or findings were documented and treated, then the EGD can be billed as well as the BRAVO (91035). Unfortunately, if the EGD was performed solely to place the capsule and not for diagnostic purposes, the EGD cannot be billed (see excerpt below).

Effective 10-1-09 per CCI policy, Chapter XI, section F, #2:

The gastroesophageal reflux test described by CPT code 91035 requires attachment of a telemetry pH electrode to the esophageal mucosa. If a physician uses endoscopic guidance to attach the electrode, the physician should not report CPT codes 43234 (upper GI endoscopy, simple primary exam ... ) or 43235 (upper GI endoscopy ... , diagnostic ... ) for the guidance procedure. The guidance is not separately reportable. Additionally, it would be a misuse of CPT codes 43234 or 43235 since these codes do not describe guidance, but a more extensive diagnostic endoscopy.

# Medicare E-Prescribing Incentives

To avoid a 1.5 percent Medicare reimbursement penalty in 2013, providers must submit 10 unique electronic prescriptions from January to June 2012. Members would include the G8553 code on any Medicare claim for an encounter during which an electronic prescription is provided.

CMS allows four “hardship exemptions” to avoid the 2013 payment penalty:

- Provider is in an area with limited high-speed Internet access.
- Provider is in an area with limited e-prescribing-ready pharmacies.
- Provider cannot e-prescribe due to local or state laws/regulations.
- Provider prescribed fewer than 100 prescriptions during the six-month reporting period.

A provider requesting a “significant hardship” exemption for the 2013 payment penalty must provide the following information to CMS by June 30, 2012:

- The name of practice or provider identifying information.
- The applicable significant hardship exemption(s).
- A justification statement.
- Attestation of the accuracy of the information.

This information should be sent to CMS via the following website:

[https://qualitynet.org/portal/server.pt/community/communications\\_supprt\\_system/234](https://qualitynet.org/portal/server.pt/community/communications_supprt_system/234).

Additionally, providers may receive a 1 percent Medicare bonus in 2012 for e-prescribing 25 times from January to December 2012. However, these prescriptions must be on Medicare claims associated with the following denominator codes:

90801	90808	96150	99204	99215	99309	99326	99337	99348
90802	90809	96151	99205	99304	99310	99327	99341	99349
90804	90862	96152	99211	99305	99315	99328	99342	99350
90805	92002	99201	99212	99306	99316	99334	99343	G0101
90806	92004	99202	99213	99307	99324	99335	99345	G0108
90807	92014	99203	99214	99308	99325	99336	99347	G0109

A provider eligible to receive the 1 percent Medicare incentive payment will also avoid a 2 percent Medicare reimbursement penalty in 2014, as the criteria for the 2013 incentive payment and 2014 payment penalty are the same (January to December 2012; 25 e-prescriptions with one of the denominator codes).

Read more information on the [AMA CPT process](#).

Read more information on [ICD-9](#) and [ICD-10](#).

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

- [Adam Borden](#), AGA, 301-941-2629
- [Brad Conway](#), ACG, 301-263-9000
- [Samuel Reynolds](#), ASGE, 630-570-5643

## Glossary of Terms

AMA	American Medical Association
CCI	Correct Coding Initiative
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
EGD	Esophagogastroduodenoscopy
ERCP	Endoscopic Retrograde Cholangiopancreatography
EUS	Endoscopic Ultrasound
IBD	Inflammatory Bowel Disease
ICD	International Classification of Diseases
MPFS	Medicare Physician Fee Schedule
PQRS	Physician Quality Reporting System
RUC	Relative Value Scale Update Committee
RVU	Relative Value Unit