

## What's new: CPT coding changes for 2010

Glenn D. Littenberg, MD, ASGE CPT Advisor

Joel V. Brill, MD, AGA CPT Advisor

Daniel C. DeMarco, MD, ACG CPT Advisor

On October 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released its final physician rule for 2010. Absent Congressional intervention, the largest impact on gastroenterology practice will be a 21.3 percent cut in Medicare physician payments effective on January 1, 2010. This negative update is required under the sustainable growth rate (SGR) formula and includes the cumulative impact of the Tax Relief and Health Care Act of 2006 (TRHCA).

In addition to the SGR-based cut, the combined impact of all fee schedule changes for gastroenterology payments (work, practice expense transition and medical liability) is -1 percent for 2010. Taking into account overall changes in the fee schedule, gastroenterology would be impacted by a 22.3 percent cut if the SGR formula is not addressed for 2010.

<b>Impact on Medicare charges by specialty under 2010 physician fee schedule final rule (Does not include impact of 21.3 negative update to conversion factor)</b>					
<b>Specialty</b>	<b>Allowed charges (millions)</b>	<b>Impact of work RVU changes</b>	<b>Impact of PE- RVU changes</b>	<b>Impact of malpractice RVU changes</b>	<b>Total impact</b>
<b>Total</b>	<b>\$77,796</b>	0%	0%	0%	0%
Gastroenterology	\$1,792	-2%	0%	1%	-1%

RVU: Relative Value Units

### Changes to consultation codes

For several years, CMS has argued that physicians were not using consultation codes properly. They were using such codes in situations where patients were self-referred, where no documentation of consultation was evident from the referring source's chart or where the physician was expected to assume care of part or all of the patient's problems at the first encounter (the so-called transfer of care).

Despite opposition from the specialty societies, in the final rule, CMS has decided to stop making payments for consultation services starting January 1, 2010, stating that in most cases, there is no substantial difference in work between consultations and visits. CMS directs that the inpatient consultation codes (99251-99255) will now be reported with the 99221-99233 inpatient initial admission service codes. In the office setting, the consultation codes (99241-99245) should be reported with codes from the 99201-99205 series if the patient is new or has not been seen within three years for a face-to-face Evaluation and Management (E/M) encounter, and with codes 99212-99215 if the patient has been seen within three years.

As of January 1, 2010, claims with consultation codes for Medicare fee-for-service beneficiaries will be rejected by the Medicare contractors and will need to be resubmitted

with different E/M codes as described above. These errors will not be cross walked by contractors to the allowed codes. How bills to Medicare as a secondary insurer will be handled is not clear. Commercial plans and Medicaid are still expected to recognize consultation code billings. If members hear of examples to the contrary, the GI societies should be informed so that our advocacy efforts can be applied.

### **CPT changes for 2010**

In addition to the changes prescribed by CMS in the 2010 final rule, several changes were made to the Current Procedural Terminology (CPT) used to report gastroenterology services for 2010 based on the work of the GI societies and their advisors through the American Medical Association's (AMA) CPT process. The changes are included in the CPT 2010 codebook. Note that underlined words/phrases in code descriptors throughout the article represent new changes. The changes are outlined below.

### **Cholangioscopy/Pancreatography**

The GI societies advocated that code 43273 be used for an add-on procedure to one or more endoscopic retrograde cholangiopancreatography (ERCP) services provided on the same day, including code 43262, ERCP with sphincterotomy. CMS concurred and implemented the recommended language as follows:

- +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 43260-43265, 43267-43272)

### **CT Colonography**

In place of the current two Category III codes (0066T and 0067T) to describe computed tomographic colonography (CTC), three Category I codes have been created: two codes to describe a diagnostic CTC study performed either without contrast (74261) or with contrast, including non-contrast images if performed (74262); and one code to describe a screening CTC study (74263).

A non-contrast CTC diagnostic study is of value in those patients for whom an instrument colonoscopy of the entire colon is incomplete due to an obstructing neoplasm. A contrast-enhanced diagnostic study may be useful in some patients after incomplete endoscopy to characterize indeterminate colonic masses or to better visualize colonic segments containing excess fluid.

The new CTC descriptor includes the phrase "including image post processing," to clarify that both two-dimensional and three-dimensional rendering is included and not reported separately. To report one of these CTC codes, interpretation of the entire exam (i.e., both intra- and extraluminal evaluation) must take place.

- 74261 Computed tomographic (CT) colonography, diagnostic, including image post processing; without contrast material
- 74262 Computed tomographic (CT) colonography, diagnostic, including image

post processing; with contrast material(s) including non-contrast images, if performed

(Do not report 74261, 74262 in conjunction with 72192-72194, 74150-74170, 74263, 76376, 76377)

74263 Computed tomographic (CT) colonography, screening, including image post processing

(Do not report 74263 in conjunction with 72192-72194, 74150-74170, 74261, 74262, 76376, 76377)

### **Photodynamic Therapy**

An editorial change was made to codes 96570 and 96571 to allow these codes to be reported for photodynamic therapy procedures performed anywhere in the gastrointestinal tract. These codes are “add-ons” to the endoscopy series codes that describe ablation – code 43228 if endoscopy is confined to the esophagus, code 43258 if esophagogastroduodenoscopy is performed or code 43272 for ERCP with ablation (43272) of biliary tree lesions, such as cholangiocarcinoma.

+96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)

+96571 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)

(96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes)

(Use 96570, 96571 in conjunction with 31641, 43228 as appropriate)

### **Evaluation and Management: Consultations**

For 2010, there are changes to the introductory language in CPT for consultation services. While CMS will no longer recognize consultation codes, these guidelines apply to private payers who will continue to recognize them. Contact your payers to learn about any policy changes related to billing for consultation services.

### **Concurrent Care and Transfer of Care**

As stated in the CPT 2010 E/M guidelines: *Concurrent care is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing*

consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem (emphasis added).

The written or verbal request for consultation may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source.

For inpatient consultation codes, only one consultation should be reported by a consultant per admission. Subsequent services provided during the same admission are reported using codes for subsequent hospital visits (99231-99233), including services to address a new problem. Use subsequent hospital care codes to report transfer of care services. Do not report both an outpatient consultation and inpatient consultation for services related to the same inpatient stay.

If the patient is seen in the emergency department (ED) in consultation and was admitted, but the consulting physician did NOT see the patient on the inpatient unit/floor on that same day, the outpatient consultation would be reported with the ED as place of service. If the patient was seen in the inpatient unit on the admission day, then all the E/M services provided related to the admission would be reported with the inpatient consultation codes (99251-99255) or inpatient admission codes (99221-99223).

### **Gastrostomy**

For 2010, CPT issued clarification to the following codes:

- 43760      Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance  
(To report fluoroscopically guided replacement of gastrostomy tube, use 49450)
  
- 43761      Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition

### **Hemorrhoid**

For 2010, CPT revised the clarification language for this section and revised the following code as follows:

For incision of thrombosed external hemorrhoid, use 46083. For ligation of internal hemorrhoid(s), see 46221, 46945, 46946. For excision of internal and/or external hemorrhoid(s), see 46250-46262, 46320. For injection of hemorrhoid(s), use 46500. For destruction of internal hemorrhoid(s) by thermal energy, use 46930. For destruction of hemorrhoid(s) by cryosurgery, use 46999. For hemorrhoidopexy, use 46947.

46221 Hemorrhoidectomy, internal, by rubber band ligation(s)

### **ICD-9-CM Codes**

For 2010, there are several new ICD-9 codes:

#### **New ICD-9-CM Procedure Codes:**

46.86 Endoscopic insertion of colonic stent(s)  
46.87 Other insertion of colonic stent(s)

#### **New ICD-9-CM Diagnosis Codes:**

569.71 Pouchitis  
569.79 Other complications of intestinal pouch  
569.87 Vomiting of fecal matter  
779.31 Feeding problems in newborn  
778.32 Bilious vomiting in newborn  
779.33 Other vomiting in newborn  
779.34 Failure to thrive in newborn  
787.04 Bilious emesis  
789.7 Infantile colic  
V15.80 History of failed moderate sedation

### **ICD-10 changes in 2013**

The major change in coding will come on October 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 four 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 Web site](#). Read [CMS information about ICD-10](#).

### **Recovery Audit Contractors**

Medicare's Recovery Audit Contractors (RACs) are now operating in all regions. While RACs are not able to review claims paid prior to October 1, 2007, RACs will be able to look back three years from the date the claim was paid. The RACs detect and correct past improper payments so that CMS and its contractors can implement actions that will prevent future improper payments. For more information about the RAC program, see [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC).

### **The four RACs are:**

Region A: Diversified Collection Services  
Region B: CGI  
Region C: Connolly Consulting, Inc.  
Region D: HealthDataInsights, Inc.

CMS requires each RAC to submit potential target codes of interest for approval. All approved "projects" are posted on the regional RAC's Web site.

Please see the [CMS website](#) and the tri-society comments on the [2010 Medicare Physician Fee Schedule](#) and [Ambulatory Surgery Center Payment System](#) for more information on the 2010 Physician Final Rule.

For more information on the AMA CPT process, see <http://www.ama-assn.org/ama/no-index/physician-resources/3882.shtml>.

For more information on ICD-9 code changes, see [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp).

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

Adam Borden, AGA                    [aborden@gastro.org](mailto:aborden@gastro.org)  
Brad Conway, ACG                 [bconway@acg.gi.org](mailto:bconway@acg.gi.org)  
Martha Espronceda, ASGE        [mespronceda@asge.org](mailto:mespronceda@asge.org)

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