

### CODING PITFALLS IN THE ASC

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### TOP CODING PITFALLS

- 1. Screening vs. Surveillance vs. Diagnostic Colonoscopy
- 2. New CMS Preventative Services codes for screening/surveillance procedures
- 3. Appropriate use of modifiers in the ASC
- 4. Update on MAC & IV Sedation Services
- 5. Appropriate Reporting of unlisted procedures



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### AVERAGE RISK VS HIGH RISK SCREENING

Definition of screening: lack of symptoms and abnormalities

- Patient is eligible for screening colonoscopy by most payers after age 50. Benefits vary based on patient/employer plans.
- African American patients should begin average risk screening at age 45 per AGA standards but CMS does not include that in their policy on G0121.
- Most commercial payers follow AGA recommendations but that should be verified during predetermination/verification of eligibility
- Medicare covers at 100% with no patient financial responsibility since January 1, 2011.
- Allowed every 10 years by Medicare. Frequency for commercial payers is dependent upon patient coverage/plan.



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### AVERAGE RISK VS HIGH RISK SCREENING

- High risk screening: patients who have a personal history of colon polyps, personal history of colon cancer, family history of colon polyps, family history of colon cancer, patients with inflammatory bowel disease,
  - Per Medicare, family history includes only first degree relatives (siblings, parents, or children)
  - Per commercial payers, may also include 2 or more second degree relatives. (This is dependent upon each plan)
  - Previous colon polyps were adenomatous not hyperplastic
  - Repeat screening covered by Medicare after a minimum of 2 years and covered at 100%.
  - **May not be considered screening but surveillance by commercial payers and may not be covered under preventive benefits in patient/employer plan. This causes much misunderstanding by patients.**




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### DIAGNOSTIC COLONOSCOPY

- Patient has symptoms and abnormalities that prompt a need for endoscopic evaluation.
- There is no such thing as symptoms and screening. This is contradictory and the indication on the history and physical and endoscopy report should be clear.
- There is a possibility that a patient may exhibit a symptom that does not prompt the need for endoscopic evaluation. However, don't make that assumption/decision on your own.
- **TIP/RULE: JUST BECAUSE A PATIENT HAS A SYMPTOM DOESN'T NECESSARILY MEAN THAT THIS WILL BE A DIAGNOSTIC COLONOSCOPY. THIS NEEDS TO BE CLARIFIED WITH THE PHYSICIAN AND REPORT AMENDED BEFORE CHARGES ARE SUBMITTED ON THE CLAIM.**




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### SCREENING VS DIAGNOSTIC COLONOSCOPY

- Patients with Medicare coverage must still pay a coinsurance when a polyp is removed as a result of the screening colonoscopy. That only applies to average screening, not high risk screening. Medicare still covers high risk screening at the same rate as average risk screening but commercial payers may not. Some will impose standard benefits to those patients with a personal history of polyps, cancer, or GI disease.
- There are exceptions to the HHS policy. Grandfathered plans do not have to follow those guidelines. That is another question to ask when verifying eligibility.




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HOW DO I MAKE MY PATIENTS UNDERSTAND THE DIFFERENCE.

- This has to be done at the time of scheduling. This does definitely require a team effort.
- The provider has to be clear as to the intent of the procedure.
- The scheduler at the practice should defer scheduling the procedure if there is contradictory information provided.
- Staff doing preauthorization also has to verify eligibility/predetermination of the patient and inform the patient or if that employee doesn't do patient teaching, he/she must relay information to the appropriate staff member.
- The staff member that gives the patient instructions should make this clear to the patient utilizing material similar to that in your workbook in chapter 2. This means that the patient might have to pay a deposit at the time of the procedure. This also means that the patient may wish to cancel or postpone the procedure.




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HOW DO I MAKE MY PATIENTS UNDERSTAND THE DIFFERENCE?

- The patient has a right to refuse treatment. However, you need to have information as to payment plans or financial help readily available for your patients.
- The ASC scheduler should also verify the indication of the procedure and question any contradictions.
- Upon arrival to the ASC, the indication also needs to be verified.
- The provider often can get conflicting information and again, just because the patient has a symptom, does that symptom prompt the need for surgical or diagnostic endoscopy. If so, the patient should be informed at that time prior to the procedure.




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HOW DO I MAKE MY PATIENTS UNDERSTAND THE DIFFERENCE.

**Can the physician change, add or delete my diagnosis so that I can be considered eligible for colon screening?**

•**No!** The patient encounter is documented as a medical record from information you have provided as well as what is obtained during taking our pre-procedure history and assessment. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

•Patients need to understand that strict government and insurance company documentation and coding guidelines prevent a physician from altering a chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law with fines and/or jail time.




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HOW DO I MAKE MY PATIENTS UNDERSTAND THE DIFFERENCE.

What if the insurance company tells the patient that the doctor can change, add or delete a CPT or diagnosis code?

•This happens a lot. Often the representative will tell the patient that if the "doctor had coded this as a screening, it would have been covered differently. However, further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient.

•Most practices will offer three way conferences between the payer, themselves, and the patient. Usually, the payer will back down and agree with the practice.



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COLORECTAL SCREENING CODES

**G0121** – Colorectal cancer screening on an individual not at high risk

•To be used for colonoscopy for individual at low risk for screening.

•Is covered at a frequency of once every 10 years months (at least 119 months from the last screening colonoscopy) for those at low risk of colon cancer

•Only diagnosis code submitted is Z12.11

•Accepted by most commercial payers



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COLORECTAL SCREENING

• Z12.11 Pertains to encounter for colon screening. ICD-10 instructs us to only use this code on asymptomatic patients and if the patient has symptoms, only to use the symptoms, not both screening and symptoms since this is contradictory.



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**COLORECTAL SCREENING  
CODES**

**G0105** – Colorectal cancer screening on an individual at high risk

- To be used for colonoscopy for individual at high risk for screening.
- Is covered at a frequency of once every 2 years months (at least 23 months from the last screening colonoscopy) for those at high risk of colon cancer
- The only code submitted that starts the time clock is a G-code. Z-codes and the PT modifier does not start the time clock.)
- Accepted by most Commercial Payers




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**WHAT ABOUT PATHOLOGY AND  
ANESTHESIA SERVICES?**

The diagnosis codes on those services should also match to support screening.

- Pathology services don't require the screening modifiers and are dependent upon the diagnosis codes for screening.
- Anesthesia claims do require the 33 modifier for average risk screening and the PT modifier for an attempted screening converted to therapeutic colonoscopy by Medicare payers. Individual payers may not recognize the PT modifier but will recognize the primary diagnosis in order to trigger preventive benefits.




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**BOWEL PREP FREE OF COST  
SHARING**

- Per the link on the next slide, a new FAQ was released on 4-20-2016, clarifying commercial plan requirements around coverage for bowel prep when prescribed for a screening colonoscopy.
- Question: If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, can a plan or issuer impose cost sharing for the bowel preparation medications prescribed for the procedure?




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**BOWEL PREP FREE OF COST SHARING**

Answer: No. Consistent with a previous FAQ, the required preparation for a preventive screening colonoscopy is an integral part of the procedure. Bowel preparation medications, when medically appropriate and prescribed by a health care provider, are an integral part of the preventive screening colonoscopy, and therefore, are required to be covered in accordance with the requirements of PHS Act section 2713 and its implementing regulations (that is, without cost sharing, subject to reasonable medical management).

[https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31\\_Final-4-20-16.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf)



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**EXAMPLE #1:**

**Indication:** Colon Screening

**Post-endoscopy finding:** Normal colonic mucosa

**Procedure Code:**

G0121: Average risk screening

• Or (for those payers not accepting G0121)

45378-33: Diagnostic colonoscopy with modifier 33 indicating this is a preventive service.

**Diagnosis Code:**

Z12.11 Special screening for malignant neoplasms, colon



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**EXAMPLE #2:**

**Indication:** Personal history of colon polyps, Colon screening

**Post-endoscopy Findings:** Normal colonoscopy

**Procedure Code:**

G0105: High risk screening

• Or (for those payers not accepting G0121)

45378-33: Diagnostic colonoscopy with modifier 33 indicating this is a preventive service.

**Diagnosis Codes:**

Z86.010 Personal history of colon polyps

(Some commercial policy indicates to bill Z12.11 with the above codes on an asymptomatic patient but this is only found in some policies, NOT ALL)



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EXAMPLE 3:

**Indication:** Iron Deficiency Anemia  
**Post-endoscopy Findings:** Normal colonoscopy  
**Procedure Code:**  
45378: Diagnostic colonoscopy  
**Diagnosis Code:**  
D50.9 Iron deficiency anemia, unspecified



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EXAMPLE #4:

**Indication:** Colon screening  
**Post-endoscopy Findings:** Polyp in the cecum and sigmoid colon  
**Procedure:** Colonoscopy with removal of cecal and sigmoid polyps by snare technique.  
**Procedure Code:**  
45385: Colonoscopy with removal of polyp by snare  
Modifier PT should be added if Medicare patient or Modifier 33 should be added if non-Medicare to trigger preventive benefits  
**Diagnosis Code:**  
Z12.11 Special screening for malignant neoplasms, colon  
D12.0 Benign neoplasm, cecum  
D12.5 Benign neoplasm, sigmoid colon (Per ICD-10 instructions, can only assign the benign neoplasm codes based on pathology report)  
(MACs: Noridian, NGS, Palmetto and First Coast do not want the Z code submitted as the primary diagnosis when using the PT modifier)



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EXAMPLE #5:

**Indication:** Personal history of colon polyps. Colon screening  
**Post-endoscopy Findings:** Huge 6 cm sessile polyp in the rectum most likely villous adenoma pending pathology  
**Procedure:** Colonoscopy with biopsy of rectal polyp. Will await pathology and consider surgical referral  
**Procedure Code:**  
45380: Colonoscopy with biopsy  
Modifier PT should be added if Medicare patient or Modifier 33 should be added if non-Medicare to trigger preventive benefits  
**Diagnosis Code:**  
Z86.010 Personal History of colon polyps  
D12.8 benign neoplasm, rectum or D37.5 Neoplasm uncertain behavior, intestines and rectum. (should be based on pathology report.)  
(MACs: Noridian, NGS, Palmetto and First Coast do not want the Z code submitted as the primary diagnosis when using the PT modifier)



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EXAMPLE #6:

**Indication:** Colon screening, change in bowel habits, diarrhea

**Post-endoscopy Findings:** Normal colon

**Procedure:** Colonoscopy

**Procedure Code:**

Can't submit charge until after reviewing with provider. Indications contradict each other.



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EXAMPLE #6 (CONTINUED):

- The presence of a symptom and screening is contradictory. This should be legally corrected before billing. Payers are going back and reviewing those claims that were paid as "screening" to see if the patient actually did have symptoms and it was billed incorrectly. If billed incorrectly, the practice will have to pay back the carrier and obtain payment from the patient, often on procedures that may have been done several years ago. For individual state guidelines, contact your State Insurance Commissioner to find out if your state has a statute of limitations as to how far back a payer can go to collect "improper payments".



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NEW CODES FOR PROLONGED PREVENTIVE SERVICES (PPS)

- Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare Physician Fee Schedule, and both deductible and coinsurance do not apply. G0513 and G0514 for prolonged preventive services will be added as part of January 1, 2018, HCPCS update and the coinsurance and deductible will be waived.

• <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10181.pdf>

• <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/MedicarePPS-Preventive-Services.html>



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NEW CODES FOR PROLONGED PREVENTIVE SERVICES (PPS)

- G0513 Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
- G0514 Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)




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NEW CODES FOR PROLONGED PREVENTIVE SERVICES (PPS)

|         | Facility Total RVUs | Non-Facility Total RVUs | Work RVUs |
|---------|---------------------|-------------------------|-----------|
| • G0513 | 1.73                | 1.84                    | 1.17      |
| • G0514 | 1.73                | 1.84                    | 1.17      |




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NEW CODES FOR PROLONGED PREVENTIVE SERVICES (PPS)

Primary Procedure Codes Specific to Gastroenterology

- G0104 Ca screening; flexible sigmoidoscopy
- G0105 Colorectal screening; high risk individual
- G0121 Colon ca screening not high risk individual




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**NEW CODES FOR PROLONGED PREVENTIVE SERVICES (PPS)**

- The descriptor for G0513 indicates first 30 minutes beyond the usual service. That means that practices (physicians) will have to establish a usual service time for the codes G0104, G0105 and G0121. Not valid for diagnostic or surgical colonoscopy codes.
- This means that your physicians will have to document the total time and also indicate why it took longer than usual in order to support the add-on codes.
- In order to report the add-on code, recommend putting what normal time for the procedures are in the comment field (Box 19) and then entering total time.  
Example for G0121:  
Total time 45 minutes, usual time for G0121: 15 minutes
- Don't be surprised if claims are pended and records are requested prior to payment




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**CORRECT REPORTING OF MODIFIER 53/74: WHEN TO BILL FLEXIBLE SIGMOIDOSCOPY**

- Given that the CPT definition of an incomplete colonoscopy also includes colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016. Incomplete colonoscopies are reported with Modifier 53. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.
- Per 2016 CPT instructions, if the scope is not advanced past the splenic flexure, only flexible sigmoidoscopy is to be reported. If the patient is undergoing a screening colonoscopy and the scope does not get as far as the splenic flexure, modifier 53 should be added to G0104 so the patient would be eligible for a completion colonoscopy after re-prep.
- When the ASC reports modifier 74 in this situation, the facility fee is still covered at 100%




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**CORRECT REPORTING OF MODIFIER 53/74: WHEN TO BILL FLEXIBLE SIGMOIDOSCOPY**

- 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. There is no surgical technique done.
- There is a set fee for colonoscopy with the 53 modifier in the Medicare fee schedule. 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 such as tortuosity.
- 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 complete examination.




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**CORRECT REPORTING OF MODIFIER 53:  
WHEN TO BILL FLEXIBLE  
SIGMOIDOSCOPY**

**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. ASC would add modifier 74 to their claims.

**Diagnosis Code:**

K92.1 Hematochezia

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



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**CORRECT REPORTING OF MODIFIER 53:  
WHEN TO BILL FLEXIBLE  
SIGMOIDOSCOPY**

**Indication:** Average risk colon screening

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

**Procedure:** Incomplete colonoscopy or flexible sigmoidoscopy? Did the scope get beyond the splenic flexure?

**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

Modifier 74 would be required for ASC claims

**Diagnosis Code:**

Z12.11 Encounter for screening for malignant neoplasm of colon

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



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**CORRECT USE OF MODIFIER 59**

• Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59

• Example: Colonoscopy with biopsy of rectum and snare polypectomy of sigmoid colon. Modifier 59 or XS would be assigned to the "bundled" code of 45380.

• 45385 Enter "sigmoid colon" in comments

• 45380-59 or (XS) Enter "rectum" in comments



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### CORRECT USE OF MODIFIER 59

- Example: EGD with biopsy of gastritis in stomach and application of bleeding duodenal ulcer. Modifier 59 or XS would be assigned to the "bundled" code of 43255.
- 43255-59 or (XS) Enter "duodenal ulcer" in comments
- 43239 Enter "stomach" in comments
- HINT: CONTROL OF BLEEDING IS PART OF ANY SURGICAL PROCEDURE AND CAN ONLY BE BILLED IF THE AREA TREATED IS COMPLETELY SEPARATE FROM THE SURGICAL PROCEDURE. DIAGNOSIS CODE HAS TO BE BLEEDING DIAGNOSIS CODE.
- HINT: THE 59 MODIFIER IS ASSIGNED TO CONTROL OF BLEEDING EVEN THOUGH IT IS THE MOST EXPENSIVE/HIGHEST RVU. COMMON SENSE HAS NOTHING TO DO WITH ASSIGNING MODIFIER 59. IT IS ALWAYS BASED ON THE COMPONENT CODE NOT THE LEAST EXPENSIVE CODE.
- HINT: UTILIZE COMMENT FIELD (BOX 19) AND LIST LOCATION OF EACH LESION TREATED NEXT TO EACH PROCEDURE.




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### NEW CCI BUNDLING EDIT

Effective January 1, 2018 – there is a new bundling edit in place per CMS NCCI edits:

|       |       |          |   |   |   |   |
|-------|-------|----------|---|---|---|---|
| 43248 | 43239 | 00180101 | * | 1 | 1 | Missuse of column two code with column one code |
| 43249 | 43239 | 00180101 | * | 1 | 1 | Missuse of column two code with column one code |

- Be sure the biopsy is done to a completely separate area as the dilation when you submit modifier 59 on 43239
- There should be a completely separate diagnosis code for the biopsy
- Example: A stricture was found in the esophagus which was dilated by balloon and an area of chronic gastritis was found in the stomach which was biopsied.
- 43249 – K22.2
- 43239-59 – K29.50




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### 2018 CHANGES TO ANESTHESIA CODES

Effective January 1, 2018, CPT codes 00740 and 00810 are deleted. Report codes listed below.

- 00731 Anesthesia for upper GI endoscopic procedures, endoscope introduced proximal to the duodenum, not otherwise specified (5 base units)
- 00732 Anesthesia for ERCP (6 base units)
- 00811 Anesthesia for lower GI endoscopic procedures, endoscope introduced distal to duodenum, not otherwise specified (4 base units)
- 00812 Anesthesia for screening colonoscopy (Report 00812 to describe anesthesia for any screening colonoscopy regardless of ultimate findings) (3 base units)
- 00813 Anesthesia for combined upper and lower GI endoscopic procedures, endoscope introduced both proximal and distal to the duodenum (5 base units)




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2018 ANESTHESIA CHANGES

- 00811 is used on patients undergoing diagnostic colonoscopies: Patients with symptoms, abnormalities and chronic diseases.
- 00812 is used on patients undergoing screening colonoscopies: average risk screening colonoscopy (G0121) and high risk screening colonoscopy (G0105).
  - Will have to see how payers will cover this code when personal history and/or family history codes are used on these patients. CMS has indicated this will be a no cost code to the patients but commercial payers have their own policies on those patients undergoing surveillance colonoscopies. Will have to wait on further instructions from all payers as we get closer to 2018.
- Remember that even if something is found and biopsies or polypectomies are done, we are still to report this anesthesia code NOT 00811.




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2018 ANESTHESIA CHANGES

- 00813 is used on patients undergoing double procedures of EGD and colonoscopy.
  - If screening is the indication for the colonoscopy, we are unsure of how to report this service. Will the 33 modifier need to be added or will this have to be reported differently?
  - Nothing has been published yet to address this scenario.




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CMS MEDLEARN MATTERS: 2018 ANESTHESIA SERVICES

- Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT Code 00812 will be added as part of January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00812 and waive the deductible and coinsurance.
- When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00811 and waive only the deductible when submitted with the PT modifier.
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10181.pdf>




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**DOCUMENTATION REQUIREMENTS FOR CONSCIOUS SEDATION BY GI PROVIDER**

- There will still have to be an anesthesia risk assessment done on every patient to include:
  - Patient past medical and surgical history with emphasis on cardiovascular, pulmonary, airway, or neurological conditions
  - Review of the patient's previous experiences with anesthesia and/or sedation
  - Family history of sedation complications
  - Summary of patient's medication list
  - Drug allergy and intolerance history



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**DOCUMENTATION REQUIREMENTS FOR CONSCIOUS SEDATION BY GI PROVIDER**

- Still has to be a problem focused exam:
  - Mouth, jaw, oropharynx, neck and airway for Mallampati score assessment
  - Chest and lungs
  - Heart and circulation
  - Vital signs
- Review of any pre-sedation diagnostic tests
- Completion of a pre-sedation assessment form (with an ASA Physical Status classification)
- Patient informed consent
- Immediate pre-sedation assessment prior to first sedating doses and initiation of IV access and fluids to maintain patency



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**DOCUMENTATION REQUIREMENTS FOR CONSCIOUS SEDATION BY GI PROVIDER**

- Begins with administration of the sedating agent
- Ends when the procedure is completed, the patient is stable for recovery status, and the physician or other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient
- Includes ordering and/or administering the initial and subsequent dose of sedating agents
- Requires continuous face-to-face attendance of the physician or other qualified health care professional
- Requires monitoring patient response to the sedating agents
- Periodic assessment of the patient
- Further administration of agents needed to maintain sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure



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**DOCUMENTATION REQUIREMENTS FOR CONSCIOUS SEDATION BY GI PROVIDER**

- Name: AB Patient                      MRN# 005555                      Dr. Eddie Endo
- University Hospital
- Date: 12/14/16
- Procedure: Flexible Sigmoidoscopy – with decompression (procedure start time: 1310)
- Indications: Sigmoid Volvulus
- ASA Class 2
- Sedation: Demerol 25mg IV, Versed 2mg IV (start time 1305: stop time 1340)
- \*Please see \_\_\_\_\_ RN notes in patient's medical record for continuous monitoring during sedation services (periodic patient assessment, administration of agents, and monitoring of oxygen saturation, heart rate, and blood pressure)




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**CMS: MODERATE SEDATION SERVICES FURNISHED WITH COLORECTAL CANCER SCREENING TEST PUB 100-04 MEDICARE CLAIMS PROCESSING, TRANSMITTAL 3763, CHANGE REQUEST 10075**

- HCPCS code G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; patient age 5 years or older (additional time may be reported with 99153, as appropriate).
- Effective for claims with dates of service on or after January 1, 2017, contractors shall not apply deductible and coinsurance to claim lines with HCPCS codes G0500 or 99153 when billed with modifier 33 and shall not apply the deductible to claim lines with HCPCS code G0500 or CPT code 99153 when submitted with the PT modifier.




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**CMS: MODERATE SEDATION SERVICES FURNISHED WITH COLORECTAL CANCER SCREENING TEST PUB 100-04 MEDICARE CLAIMS PROCESSING, TRANSMITTAL 3763, CHANGE REQUEST 10075**

- Clinical Examples:
  - 67-year-old Medicare patient presents for screening colonoscopy. Total sedation time monitored by Endoscopist: 14 minutes
    - Screening was normal
      - G0121: Average risk screening colonoscopy
      - G0500-33: Moderate sedation services furnished during screening colonoscopy
      - Patient's copay and deductible will be waived
  - 65-year-old Medicare patient presents for screening colonoscopy. Total sedation time monitored by Endoscopist: 21 minutes
    - Polyp located in the descending colon was removed by snare
      - 45385-PT: Colonoscopy with snare (PT for screening turned therapeutic)
      - G0500-PT: Moderate sedation services furnished during a screening colonoscopy which turned therapeutic
      - Patient's deductible is waived, copay still applies




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### ANESTHESIA/SEDATION CODING TIPS

- Make sure to instruct your anesthesia provider to give you both the primary risk/comorbidity issue as well as the indication/findings of/during the procedure.
- Make a spreadsheet with information by payer and/or payer plan as to which diagnosis should be in the primary position. This is the most common reason for denial of payment.
- Check the Medicare LCDs frequently for changes and/or additions to policy.
- Check your Commercial Payers frequently for changes and/or additions to policy.
- Make sure that you have a good way to obtain charge capture and verification of charges.
- Audit documentation frequently to make sure that all required elements are contained in the medical record.




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### ANESTHESIA/SEDATION CODING TIPS

- Make sure that documentation for conscious sedation is verified with both the endoscopy report and the anesthesia record since 10 minutes of sedation time is required in order to start billing.
- 99153 for each additional 15 minutes conscious sedation monitoring is only billable and payable when done in POS 11. Some payers have paid incorrectly on this and have recouped the money.
- Refer to the time thresholds in your CPT book in the introduction to the conscious sedation section for further clarification
- Since July 1, 2017, 99152 is bundled into all endoscopy codes as per NCCI edits. G0500 should be submitted with endoscopy codes not 99152 since G0500 is specific to gastroenterology procedures.
- Have any questions about the anesthesia records, ask your anesthesiologist/anesthetist/physician. They are your best resource.




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### APPROPRIATE BILLING FOR UNLISTED PROCEDURES

- Many advanced Endoscopists perform certain procedures that do not have a specific CPT code assignment. In these unique situations, we have to assign unlisted procedure codes.
- Payers will automatically deny any unlisted procedure billed and request documentation.
- Be sure documentation states complexity and time involved in advanced procedure cases
- Providers should create cover letters for all unlisted procedures performed.




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**APPROPRIATE BILLING FOR UNLISTED PROCEDURES**

- Claims must include a procedure description in Box 19 of the claim form
  - Medicare will deny your claim without this information. This requires you to do an error in logging adjustment on the claim in your system and submit a new claim.
  - Always wait for the denial to submit appropriate cover letter and documentation of the unlisted procedure code




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**APPROPRIATE BILLING FOR UNLISTED PROCEDURES**

- Create a fee schedule that is appropriate for the procedure performed
  - You can base this off RVU's/fees of an established procedure that is comparative to the advanced procedure
- Examples of GI Unlisted Procedures
  - Retrograde exam of the small intestine via anus or stoma colon (44799)
  - Endoscopic Submucosal Dissection (45399 for colon, 43499 for esophagus, 43999 for stomach)




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**APPROPRIATE BILLING FOR UNLISTED PROCEDURES**

- Small bowel enteroscopy with dilation (44360+44799)
- Small bowel enteroscopy with tattoo (44360+44799)
- Endoscopic Pancreatic Necrosectomy (48999)




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