Part B Insider (Multispecialty) Coding Alert

Gastroenterology: Get Set For Major Changes to Gastroenterology Coding Next Year

Also watch for ERCP changes in 2014.

You don't have to wait for the new CPT® book to release to know the changes you need to incorporate into your gastroenterology practice in 2014 — get ready to rewrite your endoscopic coding as you'll have to watch for scope type and route used for entry. While official CPT® changes have not been released, take a look at what you can expect come Jan. 1, 2014.

Reminder: Although the potential revisions below are listed as "accepted" in the CPT® editorial panel meeting summaries, it is not essential that all these changes will be taken forward in CPT® 2014. But the actual codes, descriptors, and guidelines won't be finalized until closer to the time of CPT® 2014's official publication.

Delve Deeper Into Documentation For Esophagoscopies

When your gastroenterologist performs an esophagoscopy, you currently resort to using the code ranges 43200-43232 (Esophagoscopy, rigid or flexible...). As you see from the descriptors to the codes in this code range, you use the same code irrespective of whether your gastroenterologist used a rigid scope or a flexible scope for the procedure. Also, you do not have to change your coding depending on the route your clinician used to guide the scope, namely, an oral route or a nasal route. But, if the new changes come into force, all this will change.

"The definition of the CPT® code for esophagoscopy was determined a few decades ago when rigid esophagoscopy was still being performed although was very much on the decline," says Michael Weinstein, MD, Gastroenterologist at Capital Digestive Care in Washington, D.C., and former representative of the AMA's CPT® Advisory Panel. "The rigid nature of the scope and limited visualization significantly increased the complexity and the risk of the procedure. With the development and refinement of larger channel flexible upper endoscopes there is almost nothing that cannot be performed with a flexible instrument with less risk. When a rigid scope is needed for a procedure then that service is not adequately described with the current code and therefore not proportionately valued compared to standard esophagoscopy. Splitting the flexible scope procedure from the rigid scope procedure will therefore more accurately describe the procedure, value the services correctly, and allow for the tracking of utilization of each procedure."

As per the changes, you will have to look through patient documentation to check if your gastroenterologist used a rigid scope or a flexible scope for the procedure. The currently used code range 43200-43232 will henceforth cover procedures that are performed using a flexible scope performed through the oral route.

For any esophagoscopy procedures performed using a rigid scope through the oral route, you will have to use a new code range 4319X. You also have two codes in the 4319X range that will be used for esophagoscopy procedures that are performed using the nasal route and a flexible scope.

Watch descriptor changes: The codes that you use to report any upper EGD procedures are also set for a descriptor change. So, in 2014, you might see a change to the code ranges 43235-43273 with the descriptors eliminating the words, "Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate" which is now likely to read, "Esophagogastroduodenoscopy, flexible, transoral."

Capture New Codes For Ablation and Stent Placements

If the new codes announced come into force, you are likely to see some new codes that you will have to add to your coding arsenal while eliminating some of the old ones that you were using for these procedures. So, if the recommended

new changes come into force, you are more likely to stop using the following CPT® codes in your gastroenterology practice:

- 43219 (Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent)
- 43228 (...with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique)
- 43256 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)
- 43258 (...with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique)

In addition: Along with new codes for stent placements and ablation, you are likely to be using new codes for dilation of the esophagus during an esophagoscopy or an esophagogastroduodenoscopy; transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance; and endoscopic mucosal resection. You might also have to put a stop to the use of codes to report a surgical dilation procedure using a balloon or a dilator, namely, 43456 (Dilation of esophagus, by balloon or dilator, retrograde) and 43458 (Dilation of esophagus with balloon [30 mm diameter or larger] for achalasia).

Check For Changes to ERCP Codes

While it is expected that you will also see some descriptor changes to the currently used endoscopic retrograde cholangiopancreatography (ERCP) codes, you will also be forced to chuck some of the currently used ERCP codes for stent insertions, stent change, dilation and ablation and use new codes that are being created instead. So, if the recommended changes come into force, you may have to stop using these CPT® codes in your gastroenterology practice:

- 43267 (Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube)
- 43268 (...with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct)
- 43269 (...with endoscopic retrograde removal of foreign body and/or change of tube or stent)
- 43271 (...with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct[s])
- 43272 (...with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique).