



## **2024 CPT Coding Update**

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The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and American Society for Gastrointestinal Endoscopy (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 societies' advisors continuously review Current Procedural Terminology (CPT®) and work through the AMA process to revise and add new codes, as appropriate. Our societies have prepared the 2024 CPT Coding Update on issues of interest to gastroenterologists.

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## **Category I CPT code update**

### **CPT clarifies guidance on accurately selecting CPT codes and unbundling**

Revisions have been made to the first and last paragraphs of the “Instructions for Use of the CPT Code Book” section of the preamble to the CPT book to clarify guidance on accurately selecting and assigning CPT codes.

The first paragraph directs users not to select a code that approximates the procedure or service provided. Users must select the code “that accurately identifies the procedure or service performed.” Unlisted codes, like 43499 (Unlisted procedure, esophagus) or 45399 (Unlisted procedure, colon), must be reported when no specific code exists. Modifying or extenuating circumstances should be documented in the medical record.

The last paragraph provides clarification on appropriate code assignment to avoid inappropriate unbundling of CPT codes. According to the AMA, “Unbundling refers to using multiple CPT codes for the individual parts of the procedure, either due to misunderstanding or in an effort to increase payment.”<sup>1</sup> The CPT manual clarifies that unbundling is inappropriate and offers examples for situations involving Category I and Category III codes. New language states that Category I and Category III codes can be reported together to accurately describe the complete service or procedure “if they represent separately reportable services.”

### **Office visit evaluation and management (E/M) code revisions**

CPT revised E/M office visit codes 99202-99205 and 99212-99215 to remove the time “range” in minutes from each code. When reporting based on time, clinicians must meet or exceed a single “minimum time threshold” of total time on the dates of the encounter for each code.

<b>CPT</b>	<b>2023 total time range in minutes</b>	<b>2024 "meet or exceed" total time in minutes</b>
99202	15-29	15
99203	30-44	30
99204	45-59	45
99205	60-74	60
99212	10-19	10
99213	20-29	20
99214	30-39	30
99215	40-54	40

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<sup>1</sup> <https://www.ama-assn.org/practice-management/cpt/8-medical-coding-mistakes-could-cost-you#:~:text=Unbundling%20refers%20to%20using%20multiple,an%20effort%20to%20increase%20payment>

### **Split (or shared) visits revisions**

CPT has clarified that a split (or shared visit) is defined by the substantive portion of the evaluation and management (E/M) service provided, which can be determined in two ways:

- based on the majority (over half) of the total clinical care time invested in the visit by both the physician and the accompanying qualified healthcare professional (QHP), **or**
- by a substantive portion of the medical decision making (MDM) process

For the physician to be reported as the billing provider for a shared E/M service, the 2024 CPT Split or Shared Visits Guidelines require the physician to make or approve the management plan for the number and complexity of problems addressed at the encounter for the patient and take responsibility for that plan with its inherent risk of complications, morbidity, or mortality. CPT states, “By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM.”

Further, when determining the code level, the physician does not need to interview the independent historian personally or order and/or review tests or external documents. However, the physician must personally perform any independent interpretations and external discussions when these are used in determining the reported E/M level.

In recent years, there has been confusion as the Centers for Medicare and Medicaid Services (CMS) considered how to define split or shared visits. In the 2024 Medicare Physician Fee Schedule final rule, CMS announced the adoption of the CPT definition of the “substantive portion” as of January 1, 2024, finally bringing permanent consistency between the agency’s rules for physicians and CPT’s guidance for split and shared visits.

### **Category III CPT code update**

CPT approved several GI-related Category III codes for implementation throughout 2024.

#### **Adjustment of Gastric Balloon: Effective Jan. 1, 2024**

0813T Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon

(Do not report 0813T in conjunction with 43197, 43198, 43235, 43241, 43247, 43290, 43291)

#### **Gastric Electrophysiology Mapping: Released Jan 1, 2024; Effective July 1, 2024**

0868T High-resolution gastric electrophysiology mapping with simultaneous patient symptom profiling, with interpretation and report

(Do not report 0868T in conjunction with 91132, 91133, 0779T)

The parenthetical notation for existing code 0779T was revised to include 0868T as “do not report” code:

0779T Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report

(Do not report 0779T in conjunction with 91020, 91022, 91112, 91117, 91122, 91132, 91133, 0868T)

**Endoscopic Drug Coated GI Balloon with esophagoscopy, colonoscopy and flexible sigmoidoscopy: Released Jan 1, 2024; Effective July 1, 2024**

0884T Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed

(Do not report 0884T in conjunction with 43191, 43195, 43196, 43200, 43213, 43214, 43220, 43226, 76000)

0885T Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed

(Do not report 0885T in conjunction with 45378, 45386, 76000, 0886T)

(For endoscopic balloon dilation of multiple strictures during the same procedure, use 0885T with modifier 59 for each additional stricture dilated)

0886T Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed

(Do not report 0886T in conjunction with 45300, 45303, 45330, 45340, 76000, 0885T)

(For endoscopic balloon dilation of multiple strictures during the same procedure, use 0886T with modifier 59 for each additional stricture dilated)

## **HCPCS code update**

### **New G2211 add-on code for visit complexity**

The Centers for Medicare & Medicaid Services (CMS) created HCPCS add on code G2211 to better account for the resource costs associated with visit complexity inherent to primary care and other longitudinal care. Code G2211 is payable beginning January 1, 2024, and may be submitted with Evaluation and Management (E/M) office or outpatient (O/O) visits, 99202-99215.<sup>2,3</sup>

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<sup>2</sup> <https://www.cms.gov/files/document/mm13272-edits-prevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf>

<sup>3</sup> <https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf>

CMS Code Descriptor: G2211 - Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

Per CMS, the relationship between the patient and the physician is the determining factor of when the add-on code should be billed. Documentation would support furnishing services to patients on an ongoing basis that result in care personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

Do not use G2211 when your relationship with the patient is of a discrete, routine, or time-limited nature, the associated office visit E/M is reported with modifier 25 appended or when reporting CPT code 99211.

### **SDOH Risk Assessment Established for 2024**

For 2024, CMS has established a G-code to provide reimbursement for conducting a social risk assessment of a patient: G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes). The code requires at least five minutes of assessment time and an SDOH-specific screening tool. It cannot be provided more often than every six months. It has been added to the Medicare Telehealth Services list.

### **ICD-10-CM diagnosis code update**

#### **Intestinal microbial overgrowth and SIBO**

New ICD-10-CM codes are now available for intestinal microbial overgrowth under the K63.82 family, including Small Intestinal Bacterial Overgrowth (SIBO) and Intestinal Methanogen Overgrowth (IMO).

SIBO is reported generally with code K63.821. However, when information is available on hydrogen subtype, use the more specific codes K63.8211 or K63.8212. Use K63.8219 when it is unspecified. For identification of IMO, report K63.829.

K63.82 Intestinal microbial overgrowth

K63.821 Small intestinal bacterial overgrowth

K63.8211 Small intestinal bacterial overgrowth, hydrogen-subtype

K63.8212 Small intestinal bacterial overgrowth, hydrogen sulfide-subtype

K63.8219 Small intestinal bacterial overgrowth, unspecified

K63.822 Small intestinal fungal overgrowth

K63.829 Intestinal methanogen overgrowth, unspecified

### **Z codes for social determinants of health**

Social Determinants of Health (SDOH)-related Z-codes range from Z55 to Z65. Z-codes are ICD-10-CM codes that can document your patients' SDOH data (e.g., housing, food insecurity, transportation). Identifying individuals' social risk factors and unmet needs will help inform the provision of health care services, follow-up care, and discharge planning for individual patients. Looking at the overall data may also help you better understand, more generally, the needs of the patients in your practice. Specifically, for gastroenterologists, better understanding your patient's SDOH may help you serve your patients better enabling you to identify barriers to improving uptakes for screening colonoscopies and improving overall screening rates. Data has found that a range of socioeconomic and demographic factors impact colorectal cancer screening rates and outcomes.

<b>Z55</b>	Problems related to education and literacy	<b>Z60</b>	Problems related to social environment
<b>Z56</b>	Problems related to employment and unemployment	<b>Z62</b>	Problems related to upbringing
<b>Z57</b>	Occupational exposure to risk factors	<b>Z63</b>	Other problems related to primary support group, including family circumstances
<b>Z58</b>	Problems related to physical environment	<b>Z64</b>	Problems related to certain psychosocial circumstances
<b>Z59</b>	Problems related to housing and economic circumstances	<b>Z65</b>	Problems related to other psychosocial circumstances

This [infographic](#) from CMS provides further details on the use of Z-codes and Z-code subcategories.

### **Correct Coding for Colorectal Cancer Screening**

New policies are making colorectal cancer (CRC) screenings free to more people and eliminating surprise bills, but only if doctors and facilities submit the correct procedure and diagnosis codes.

It is important to note that rules for Medicaid vary by state. Commercial plans in place on or before March 23, 2010, and employer-sponsored health care plan are not required to follow the rules below. For all other circumstances, the information below will make sure your patients are not burdened with a surprise bill.

### **Screening colonoscopy with no polyps removed**

#### **Commercial insurance**

Report CPT code 45378 with modifier 33 (preventative services) for patients with commercial insurance to prevent them from being inappropriately billed.

Commercial insurance covers the screening colonoscopy, bowel prep, sedation, lab work and the hospital or ambulatory surgery center costs where the colonoscopy was performed 100% by health insurance when no polyps are found.

### **Medicare**

Report HCPCS code G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) for individuals at high risk for colorectal cancer or G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) for individuals at low risk.

Medicare covers the colonoscopy and sedation 100% when no polyps are found.

### **Potential ICD-10-CM diagnosis codes to report**

Note that ICD-10-CM expanded specificity of the family history of colonic polyps for 2024, although, in most situations the histology of polyps in the family is not known. Check your insurers' policies to determine if Z83.719 is required.

Z12.11 Encounter for screening for malignant neoplasm of colon (Note: this code must be listed first when reporting multiple diagnosis codes)

Z12.12 Encounter for screening for malignant neoplasm of rectum (Note: this code must be listed first when reporting multiple diagnosis codes)

Z80.0 Family history of malignant neoplasm of digestive organs

Z83.71 Family history of colonic polyps

Z83.710 Family history of adenomatous and serrated polyps

Z83.711 Family history of hyperplastic colon polyps

Z83.718 Other family history of colon polyps

Z83.719 Family history of colon polyps, unspecified

Z85.038 Personal history of other malignant neoplasm of large intestine

Z85.048 Personal history of other malignant lesion of rectum, rectosigmoid junction and anus

Z86.010 Personal history of colonic polyps

### **Screening colonoscopy with polyp removal**

#### **Commercial insurance**

Select the appropriate colonoscopy CPT code based on the type of removal performed. If multiple polyps/lesions were removed using different techniques, report each method separately. Add modifier 33 to identify the polypectomy as a screening service and prevent the patient from being inappropriately billed.

45380 Colonoscopy with biopsy, single or multiple

45384 Colonoscopy with removal of lesion(s) by hot biopsy forceps

45385 Colonoscopy with removal of lesion(s) by snare

45388 Colonoscopy with ablation of lesion(s)

Colonoscopy, bowel prep, sedation, lab work and the hospital or ambulatory surgery center costs where the colonoscopy with polypectomy was performed are covered 100% by health insurance.

## **Medicare**

Select the appropriate colonoscopy CPT code based on the type of removal performed. If multiple polyps/lesions were removed using different techniques, report each method separately. Add modifier PT (colorectal cancer screening test; converted to diagnostic test or other procedure) to each CPT code reported to identify the polypectomy as a screening service and prevent the patient from being inappropriately billed.

- 45380 Colonoscopy with biopsy, single or multiple
- 45384 Colonoscopy with removal of lesion(s) by hot biopsy forceps
- 45385 Colonoscopy with removal of lesion(s) by snare
- 45388 Colonoscopy with ablation of lesion(s)

From 2023 to 2026, patient responsibility is 15% of the cost of the procedure(s), from 2027 to 2029 it falls to 10% and by 2030 it will be covered 100% by Medicare.

## **Potential ICD-10-CM diagnosis codes to report**

- Z12.11 Encounter for screening for malignant neoplasm of the colon (Note: this code must be listed first when reporting multiple diagnosis codes)
- Z12.12 Encounter for screening for malignant neoplasm of rectum (Note: this code must be listed first when reporting multiple diagnosis codes)
- D12.0 Benign neoplasm of the cecum
- D12.4 Benign neoplasm of the descending colon
- D12.8 Benign neoplasm of the rectum
- K63.5 Polyp of colon (Note: this code is used for hyperplastic polyp and can be reported when the type of polyp is not specified as adenomatous or neoplastic, which can happen when the colonoscopy is billed prior to review of the final pathology report)

## **Stool-based tests**

### **Commercial insurance**

Select the appropriate code below based on the type of test performed. add modifier 33 to the colonoscopy code to prevent the patient from being inappropriately billed for the colonoscopy following a positive non-invasive test.

- FIT: 82274 Assay test for blood, fecal
- FOBT: 82270 Occult blood, feces
- Multi-target stool DNA test: 81528 Oncology colorectal screen

Both the stool-based test and colonoscopy (including polyp removal) after a positive stool test are covered at 100% if it was done after May 31, 2022. For tests performed before May 31, 2022, the stool-based test is covered at 100%, but patients might have to pay some of the costs for the colonoscopy.

## **Medicare**

Select the appropriate code below based on the type of test performed. Add modifier KX (requirements specified in the medical policy have been met) to the screening colonoscopy



HCPCS code for Medicare to the colonoscopy code to prevent the patient from being inappropriately billed for the colonoscopy following a positive non-invasive test.

FIT: G0328 Colorectal cancer screening, fecal occult blood

FOBT: 82270 Occult blood, feces

Multi-target stool DNA test: 81528 Oncology colorectal screen

Both the stool-based test and screening colonoscopy are covered at no cost as of Jan. 1, 2023, but patients may have to pay some of the cost of the colonoscopy if polyps are removed.

**Potential ICD-10-CM diagnosis codes to report**

R19.5 Other fecal abnormalities

Z12.10 Encounter for screening for malignant neoplasm of intestinal tract, unspecified

Z12.11 Encounter for screening for malignant neoplasm of colon

Z12.12 Encounter for screening for malignant neoplasm of rectum