2015 Medicare Physician Fee Schedule
Putting the Pieces Together for GI

Colleen M. Schmitt, MD, MHA, FASGE
ASGE President

Glenn D. Littenberg, MD, MACP
Chair, ASGE Practice Management Committee and CPT Advisor
Questions?

Your Participation

Grab Tab – Click orange arrow to open/close Control Panel.

Please continue to submit your text questions and comments using the Questions Panel.

For more information, please contact [Insert Name and email].

Note: Today’s presentation is being recorded and will be available on ASGE’s website within 48 hours.
Agenda

- GI Tri-Society Reimbursement Campaign
- 2015 GI reimbursement rate changes
- 2015 GI coding and billing
- Important regulatory and compliance updates
- ASGE resources for the GI Practice
Good News

• The voice of GI was heard
• Revaluation of the colonoscopy code family was DELAYED... not STOPPED
• New transparent rate-setting process at CMS
More Still Needs To Be Done

- Proposed values will be in the CY2016 proposed rule
- Valuation of moderate sedation
  - CPT → RUC → CMS
  - Likely won’t be endoscopy specific
- Upper GI Endoscopy final values
- Time to prepare for upcoming changes
2015 Reimbursement
Lower GI Endoscopy

- Colonoscopy, Colonoscopy through Stoma, Ileoscopy, Pouchoscopy, and Flexible Sigmoidoscopy
  - Delaying implementation of changes until 2016 due to inclusion of moderate sedation
  - Many codes deleted due to new coding structure
  - CMS will be reimbursing at the CY 2014 levels
  - Use G codes to maintain 2014 levels for Medicare
  - The new CY 2015 Lower GI Endoscopy CPT codes will not be recognized by Medicare for CY 2015
  - Private payers should recognize the new 2015 CPT codes
2015 Reimbursement
Upper GI Endoscopy

• CMS finalized the values for upper GI endoscopy, EUS, ERCP
• Slight changes in reimbursement
  – Did not accept most of our objections to their methodology / valuations
  – Implications for 2016?
• Small positive updates for HOPD, ASC facility
• Adjustments of APCs based on our input
• Assumes -21% SGR penalty “patched” again
## The Damage Done: ESO, EGD 2013→2014/15 Facility-based Professional Fees

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2013 Facility Payment (CF $34.02)</th>
<th>2014 Facility Payment (CF $35.8228)</th>
<th>2015 Facility Payment (CF $35.8013)</th>
<th>% Change 2013 to 2015</th>
<th>% Change 2014 to 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>43200</td>
<td>Esophagoscopy dxtc</td>
<td>$ 106.82</td>
<td>$ 97.08</td>
<td>$ 98.45</td>
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<tr>
<td>43205</td>
<td>Esoph varices banding</td>
<td>$ 227.25</td>
<td>$ 155.47</td>
<td>$ 153.59</td>
<td>-32.4%</td>
<td>-1.2%</td>
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<tr>
<td>43211</td>
<td>Esoph EMR</td>
<td>NA</td>
<td>$ 252.91</td>
<td>$ 240.58</td>
<td>NA</td>
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<tr>
<td>43229</td>
<td>Esoph ablation eg Barryx</td>
<td>NA</td>
<td>$ 214.94</td>
<td>$ 212.66</td>
<td>NA</td>
<td>-1.1%</td>
</tr>
<tr>
<td>43235</td>
<td>EGD diagnostic</td>
<td>$ 147.99</td>
<td>$ 136.13</td>
<td>$ 134.61</td>
<td>-9.0%</td>
<td>-1.1%</td>
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<tr>
<td>43239</td>
<td>EGD biopsy</td>
<td>$ 174.52</td>
<td>$ 152.25</td>
<td>$ 151.44</td>
<td>-13.2%</td>
<td>-0.5%</td>
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<tr>
<td>43244</td>
<td>EGD varices banding</td>
<td>$ 298.36</td>
<td>$ 269.03</td>
<td>$ 266.72</td>
<td>-10.6%</td>
<td>-0.9%</td>
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<tr>
<td>43246</td>
<td>EGD G tube</td>
<td>$ 255.15</td>
<td>$ 221.03</td>
<td>$ 216.96</td>
<td>-15.0%</td>
<td>-1.8%</td>
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<tr>
<td>43248</td>
<td>EGD guide wire dil esoph</td>
<td>$ 190.85</td>
<td>$ 183.77</td>
<td>$ 182.59</td>
<td>-4.3%</td>
<td>-0.6%</td>
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<td>43255</td>
<td>EGD control bleeding</td>
<td>$ 285.77</td>
<td>$ 221.38</td>
<td>$ 219.46</td>
<td>-23.2%</td>
<td>-0.9%</td>
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<tr>
<td>43266</td>
<td>EGD stent</td>
<td>($257.19)</td>
<td>$ 145.44</td>
<td>$ 148.58</td>
<td>-42.3%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

**Putting the pieces together**
## The Damage Done: EUS, ERCP 2013→2014/15 Facility-based Professional Fees

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<tbody>
<tr>
<td><strong>EUS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43237</td>
<td>EUS diagnostic eso, stom OR duod</td>
<td>$ 236.78</td>
<td>$ 215.30</td>
<td>$ 213.02</td>
<td>-10.1%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>43238</td>
<td>EUS FNA eso, stom OR duod</td>
<td>$ 294.61</td>
<td>$ 245.74</td>
<td>$ 244.52</td>
<td>-17.0%</td>
<td>-0.5%</td>
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<tr>
<td>43242</td>
<td>EUS diagnostic eso, stom AND duod</td>
<td>$ 427.97</td>
<td>$ 280.13</td>
<td>$ 276.74</td>
<td>-35.3%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>43259</td>
<td>EUS FNA eso, stom AND duod</td>
<td>$ 307.20</td>
<td>$ 248.61</td>
<td>$ 246.31</td>
<td>-19.8%</td>
<td>-0.9%</td>
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<tr>
<td><strong>ERCP</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>43260</td>
<td>ERCP diagnostic</td>
<td>$ 350.07</td>
<td>$ 352.50</td>
<td>$ 348.70</td>
<td>-0.4%</td>
<td>-1.1%</td>
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<tr>
<td>43262</td>
<td>ERCP sphincterotomy</td>
<td>$ 432.05</td>
<td>$ 390.11</td>
<td>$ 385.58</td>
<td>-10.8%</td>
<td>-1.2%</td>
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<tr>
<td>43264</td>
<td>ERCP stone removal</td>
<td>$ 517.78</td>
<td>$ 397.63</td>
<td>$ 393.10</td>
<td>-24.1%</td>
<td>-1.1%</td>
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<tr>
<td>43274</td>
<td>ERCP stent</td>
<td>($438+$216)</td>
<td>$ 498.30</td>
<td>$ 492.27</td>
<td>(-24.8)</td>
<td>-1.2%</td>
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<tr>
<td>43277</td>
<td>ERCP balloon dilation</td>
<td>($432+$216)</td>
<td>$ 413.40</td>
<td>$ 408.13</td>
<td>(-37.1)</td>
<td>-1.3%</td>
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</tbody>
</table>
2015 Coding Changes GI Endoscopy

• New definitions & instructions, colonoscopy
• Using Modifier 52 and 53, Decision Tree
• Parallel Concepts in Endoscopy
• New codes for 2015
• CMS action, delay in 2015 valuations
• Billing G code services in 2015 and new services
Definition of Colonoscopy - Revised

- Colonoscopy is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis.
New Definition of Colonoscopy

**Screening or diagnostic:** Unable to advance the colonoscope to cecum or colon-small intestine anastomosis due to unforeseen circumstances → 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 (G0105, G0121)

**Therapeutic:** does not reach the cecum or colon-small intestine anastomosis → Colonoscopy (45379-45398) or colonoscopy through stoma code (44389-44408) with modifier 52
Screening/Colonoscopy Decision Tree

Decision to Undergo Colonoscopy

Diagnostic Procedure

- Does Not Reach Splenic Flexure
  - Flexible Sigmoidoscopy (45330)

- Beyond Splenic Flexure, But Not To the Cecum
  - Colonoscopy (45378; Modifier 53)

- To Cecum
  - Colonoscopy (45378; No Modifier)

Therapeutic Procedure

- Does Not Reach Splenic Flexure
  - Flexible Sigmoidoscopy (45331-45347)

- Beyond Splenic Flexure, But Not To the Cecum
  - Colonoscopy (45379-45398; Modifier 52)

- To Cecum
  - Colonoscopy (45379-45398; Modifier 52)
Further Instructions 2015

• Report flexible sigmoidoscopy (45330-45347) for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure.

• Clarification on coding post partial colectomy or of exam of defunctionalized colon in patient with stoma.
Parallel Concepts in Endoscopy 2015

• As in Esophagoscopy, EGD: Ablation, stent includes dilation; EMR code counterparts in flex sig, colon, colon through stoma; control of bleeding “any method”

• New codes for decompression, banding of hemorrhoids (part of flex sig, colonoscopy)
Endoscopy of Small Intestine (Enteroscopy)

• If an endoscope cannot be advanced at least 50 cm beyond the pylorus, see 43233, 43235-43259, 43266, 43270 (i.e. code as an EGD).

• If an endoscope can be passed at least 50 cm beyond pylorus but only into jejunum, see 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373.

• Did not review existing codes otherwise at CPT, not revalued by RUC.

• So some “new conventions” not applied in SB enteroscopy

• Will need to use unlisted 44799 small intestine service codes for modalities for which there is no code (submucosal injection ...)
Endoscopy of Small Intestine (Enteroscopy)

• To report retrograde examination of small intestine via anus or colon stoma, use 44799, unlisted procedure, small intestine.
Liver Elastography

91200  Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report

- The service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.
- Practice expense component of the MACHINE apparently not in CMS pricing so interim and final reimbursement???
Unlisted Procedures

New & Revised Codes

▲ 44799 Unlisted procedure, small intestine (2015 Medicare G6021)

# 45399 Unlisted procedure, colon  <moderate sedation symbol...error>
DELAY SOUGHT FOR 2015 LOWER ENDOSCOPY VALUES:

- Transparency
- RUC process
- Unresolved issues with UGI, EUS, ERCP
- Moderate Sedation: To be removed from codes in which it is now “inherent”
• In the Final Rule, CMS delayed publishing updated wRVU for the lower endoscopy codes (ileoscopy, pouchoscopy, flexible sigmoidoscopy, colonoscopy through stoma, colonoscopy) surveyed for this cycle.

• For 2015, CMS established G codes to mirror those 2014 CPT codes that were deleted in 2015.

• For 2015, CMS maintained the wRVU of these codes at the 2014 values, pending a decision on how to address removing moderate sedation from the endoscopy codes.

• Thus: Stay tuned!
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Colonoscopy through stoma</td>
<td>44393</td>
<td>G6019</td>
<td>44401</td>
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<tr>
<td>Flexible sigmoidoscopy</td>
<td>45339</td>
<td>G6022</td>
<td>45346</td>
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<tr>
<td>Colonoscopy</td>
<td>45383</td>
<td>G6024</td>
<td>45388</td>
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## Stent Placement: Old and New Codes

<table>
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<tr>
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<tbody>
<tr>
<td>Colonoscopy through Stoma</td>
<td>44397</td>
<td>G6020</td>
<td>44402</td>
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<td>Flexible Sigmoidoscopy</td>
<td>45345</td>
<td>G6023</td>
<td>45347</td>
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<tr>
<td>Colonoscopy</td>
<td>45387</td>
<td>G6025</td>
<td>45389</td>
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<tr>
<td>2014 CPT Code</td>
<td>Description</td>
<td>2015 HCPCS Code</td>
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<tr>
<td>---------------</td>
<td>---------------------------</td>
<td>-----------------</td>
<td></td>
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<tr>
<td>44383</td>
<td>Ileoscopy, stent</td>
<td>G6018</td>
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</tr>
<tr>
<td>44799</td>
<td>Unlisted proc, small intestine</td>
<td>G6021</td>
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<tr>
<td>0226T</td>
<td>High resolution anoscopy (HRA)</td>
<td>G6027</td>
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</tr>
<tr>
<td>0227T</td>
<td>HRA, biopsy</td>
<td>G6028</td>
<td></td>
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</tbody>
</table>
How to Report Lower GI Codes in 2015

• If the patient is Medicare (Original, Medicare Advantage), and:
  – If the code has not changed from 2014 to 2015
    • Physicians report the CPT code
    • CMS fees based on 2014 values
  – If the code has changed from 2014 to 2015
    • Physicians report the G code instead of new code
    • CMS fees based on 2014 values
  – If the code is new for 2015 (EMR, band ligation)
    • Physicians report the CPT code--? Which claim denial edit?
    • Not valued by CMS
    • Unlisted G6021 (unlisted service, intestine, 2014 44799)
Reporting Lower GI Endoscopy in 2015

• If the patient is Commercial, Medicaid, Exchange, etc.
  – Look for payer instructions/inquire; report the 2015 CPT code, unless instructed otherwise (professional, facility)

• How to value the new codes?
  – Look at the 2014 value of the base code
  – Look at the 2015 value of the increment (e.g. ablation, stent, EMR, injection, EUS, EUS/FNA, decompression, etc.)
  – Do the math...
  – Further assistance pending
Facilities and Reporting Endoscopy Codes

• Facilities pending further clarification!!
  – Report the 2015 CPT code
    • Regardless of whether the code is new or has not changed
    • Regardless of payer
  – Do not report the G code
    • Not valued in the OPPS fee schedule
  – Be sure your facility is using proper crosswalks
EMR Colon 2015 Medicare

• G6021 Unlisted service, colon
  – By itself or as secondary code to snare removal code
• Flex sig: 45338 + 45399
• Colon through stoma: 44394 + 45399
• Colonoscopy: 45385 + 45399
• Cover letter “colonoscopy counterpart to 43254 EGD with EMR” can suggest same $ increment (43254-43235) be added to 45378
ASGE Coding Resources

• Free Coding Questions
  – codingquestions@asge.org

• GI Tri-Society Coding Update

• Coding Primer

• 2015 Gastroenterology Coding Update Course
  – Dec. 13-14, 2014, ASGE IT&T, Downers Grove, IL

• ICD-10 Boot Camp and GI Update Course
  – April 24, 2015, ASGE IT&T, Downers Grove, IL
Coverage of Cologuard®

- Approved by Medicare on Oct. 9, 2014
- $502 reimbursement rate
- Reported using **G0464**
  - “Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3).
- Medicare Part B covers the Cologuard™ test once every 3 years for people with Medicare who meet *all* of these conditions:
  - Between 50 and 85 years old
  - Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test, and
  - At average risk of developing colorectal cancer—have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; and have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer
Talking to Patients about Cologuard®

- ASGE has developed fact sheets describing commonly used colon cancer screening tests including stool DNA.
  
  - **Patients:** [Facts About Common Colon Cancer Screening Tests](http://www.asge.org/healthcare/)
  
  - **Primary Care Physicians:** [Facts About Common Colon Cancer Screening Tests for Primary Care Physicians](http://www.asge.org/healthcare/)

See David Lazarus  LA Times
OTHER IMPORTANT CHANGES IN THE PHYSICIAN FEE SCHEDULE FINAL RULE
Definition of CRC Screening Tests

• Definition modified to include **anesthesia** that is furnished in conjunction with **screening** colonoscopy.
  – Effective Jan. 1, 2015

• Therefore, beneficiary cost-sharing obligations reduced for CRC screening.

• **Exception:** Coinsurance for colonoscopy AND separately billed anesthesia services NOT waived for screenings with polyp/growth removal.
  – Legislative correction required – Take Action @ [www.capwiz.com/asge](http://www.capwiz.com/asge)

• **Deductible** is waived for 00810 service, screening or screen→therapeutic procedure
**CRC Colonoscopy Cost-Sharing**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Screening Colonoscopy</th>
<th>Separately Billed Anesthesia with Screening Colonoscopy 00810</th>
<th>Screening Colonoscopy with Polyp Removal</th>
<th>Separately Billed Anesthesia Screening Colonoscopy with Polyp Removal</th>
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<td>2014</td>
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<tr>
<td>Coinsurance</td>
<td>Waived</td>
<td>Applies</td>
<td>Applies</td>
<td>Applies</td>
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<tr>
<td>Deductible</td>
<td>Waived</td>
<td>Applies</td>
<td>Waived</td>
<td>Applies</td>
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<tr>
<td>Final 2015 MPFS</td>
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</tr>
<tr>
<td>Coinsurance</td>
<td>Waived</td>
<td>Waived</td>
<td>Applies</td>
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<td>Waived</td>
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</tr>
</tbody>
</table>

“takes precedence over any local coverage policy that limits Medicare coverage for anesthesia services furnished during a screening colonoscopy” Really?
CMS Quality Incentive Programs

• Physician Quality Reporting Program (PQRS)
  – Increased reporting requirements in 2015 to avoid 2017 payment penalty (-2%)

• Physician Value-Based Payment (VBP) Modifier
  – Applies to all physicians in 2017
  – Modifier tied to successful PQRS participation
  – Further penalties -2% or -4% for groups if...based on 2015 reporting

• GIQuIC meets requirements

• Info published on CMS Physician Compare database
2015 PQRS Requirements
What you Need to Know to Avoid the PQRS Penalty in 2017

• ASGE Webinar
  – Dec. 8, 2014, noon EST
  – Camille Bonta, ASGE Washington Representative
  – Register: www.asge.org/practicalsolutions
ASGE PRACTICE MANAGEMENT RESOURCES
Putting the Pieces Together for GI in 2015

• Reimbursement Tools
• Regulatory Compliance
• Coding Resources
• Practice Management Tips
• Performance Improvement Module
• Webinar Series

• Best Practices
• Quality and Safety in GI Endoscopy
• Practice Management Courses
• Clinical and Practice Operations Benchmarking Tools
COMING SOON

Starting **this fall**, ASGE will be releasing a variety of new and updated resources:

- ASGE’s Practice Management Trifecta
- Endoscopic Operations Survey Databook
- Coding Primer
- Performance Improvement Module: Screening Colonoscopy
- Quality and Practice Webinars
- ICD-10 Boot Camp and GI Update Course
- Coding Tips

www.asge.org/practicalsolutions
Webinar Series
Negotiating with Payers

• Strengthening Your Bargaining Power
  – Thomas Deas, Jr., MD

• Strategic Marketing of the GI Practice
  – Feb. 10, 2015
  – Joseph Vicari, MD

• Assessing your Reimbursement
  – March 3, 2015
  – Edward Bentley, MD
Practice Management Courses
Practice Management Courses

GO GI OUTLOOK 2015
The Practice Management Conference
August 7-9, 2015
Fairmont Chicago Millennium Park
Chicago, Illinois

This is a co-sponsored program of ASGE and the AGA Institute
Practice Management Products

Coded Primer
A Guide for Gastroenterologists

The Ambulatory Endoscopy Primer
3rd Edition

A Key Piece to Improving Your Endoscopy Operations in 2015

Endoscopic Operations Survey Databook
ASGE Supports Your Commitment to High-Quality Care

ASGE offers programs aimed at empowering physicians and non-physician staffs to create high-quality endoscopy units. Strengthen the quality and safety infrastructure of your practice by participating in these ASGE quality-related programs:
Your PRIMARY resource for GI Practice Management

www.asge.org/practicalsolutions
Questions?

Your Participation

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For more information, please contact [Insert Name and email].

Note: Today’s presentation is being recorded and will be available on ASGE’s website within 48 hours.
Questions?
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