

Gastroenterology Services Payment Policy

Policy

The Plan reimburses contracted providers for covered professional gastroenterology (GI) services.

Reimbursement

The Plan reimburses the following professional services and/or components:

- Helicobacter pylori breath testing
- Colonoscopy
- Wireless capsule endoscopy; when approved through prior authorization process
- Diagnostic laryngoscopy
- Esophagoscopy for removal of a foreign body
- Esophageal endoscopy dilation
- Upper GI endoscopy
- Proctosigmoidoscopy with control of bleeding
- Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease Code 43257 – Reimbursed only for Fallon Medicare Plus, NaviCare, Summit Eldercare, and FHW PACE Plan members when prior authorization is approved.
- Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation (91035) with approved Prior authorization

The Plan does NOT reimburse the following services:

- Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease (43257) - Not reimbursed except for Fallon Medicare Plus Plan members when prior authorization is approved.
- Insertion of an intravenous catheter for intravenous fluids when submitted with GI endoscopy procedures.
- Angelchick prosthesis anti-reflux device.
- Diagnostic laryngoscopy (31525, 31575) when it is submitted with an esophagoscopy (43215) for removal of a foreign body.
- Upper GI endoscopy when billed with esophageal endoscopy dilation.
- Bard Endo-Cinch System.
- Anesthesia provided by the surgeon or gastroenterologist, including conscious sedation. This is included in the overall reimbursement for the procedure.
- Control of proctosigmoid bleeding when part of a sigmoidoscopy for removal of a foreign object.
- Endoscopic gastroplasty.
- Wireless capsule endoscopy (91111) of the esophagus.
- Hospital-mandated physician on-call services (99026, 99027).
- Diagnostic scope (45380) when billed with surgical scope involving polypectomy.
- If at one patient session multiple lesions are removed by one or multiple techniques (i.e.: one or more polyps by one or more of hot biopsy forceps, snare, etc.), only one scope code is payable – whichever has the highest value. No diagnostic scope is payable.

Referral/notification/prior authorization requirements

PCP referrals are required for all specialty visits for most products. For a description of products and services requiring a PCP referral, please refer to the PCP referral and prior authorization grid

located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

The ordering physician is required to obtain prior authorization for:

- Unlisted CPT codes
- The applicable codes found on the List of Procedures Requiring Prior Authorization located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

The Plan will use current industry standard procedure codes (HCPCS CPT I and II codes along with other industry standard codes) throughout our processing systems.

The Health Insurance Portability & Accountability Act (HIPAA) Transaction & Code Set Rule requires providers to use the procedure code(s) that are valid at the time the service is provided. The Plan adheres to HIPAA standards.

Providers must only use industry standard code sets and must use specific HCPCS CPT I and II codes when available. If specific codes are not available, unlisted codes require Plan prior authorization.

In accordance with the Patient Protection and Affordable Care Act (PPACA), Plan members have no cost sharing for preventive colorectal cancer screenings that are provided in accordance with the United States Preventive Services Task Force (USPSTF) guidelines. In order to be recognized as preventive screening, claims for services must indicate a screening ICD code in the primary diagnosis position on the claim.

The following codes will be recognized as preventive:

ICD-10 code	Description
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
Z12.13	Encounter for screening for malignant neoplasm of small intestine
Z80.0	Family history of malignant neoplasm of digestive organs

In accordance with the clarification issued by the Department of Labor regarding compliance with the Affordable Care Act, Fallon Health will remove cost-sharing from pathology services associated with routine screening colonoscopies effective January 1, 2016. In order to allow these claims to process properly, the Pathologist should bill this service under CPT code 88305. In addition, a corresponding ICD-10 code from the following list must accompany the billing of 88305:

ICD-10 code	Description
C18.0	Malignant neoplasm of cecum
C18.1	Malignant neoplasm of appendix

C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
D12.0	Benign neoplasm of cecum
D12.1	Benign neoplasm of appendix
D12.2	Benign neoplasm of ascending colon
D12.3	Benign neoplasm of transverse colon
D12.4	Benign neoplasm of descending colon
D12.5	Benign neoplasm of sigmoid colon
D12.6	Benign neoplasm of colon, unspecified
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
K62.0	Anal polyp
K62.1	Rectal polyp
K63.5	Polyp of colon
Z12.11	Encounter for screening for malignant neoplasm of colon

Failure to submit a claim with the proper CPT and ICD-10 combination may result in cost-sharing for the member. This change only applies to routine screening colonoscopies. Cost-sharing may still apply to any other pathology performed related to other colonoscopies.

Place of service

This policy applies to services furnished by physicians and qualified non-physician practitioners in all areas and settings permitted under applicable laws.

Policy history

Origination date: 05/01/2009
Previous revision date: 11/01/2009 - Added wireless capsule endoscopy of the esophagus to the list of services that FH will not reimburse.

11/01/2010 - Updated to reflect 10/1/2010 prior authorization requirement for anesthesia assistance for upper and/or lower GI endoscopic procedures.

03/01/2011 - Updated billing/coding guidelines related to diagnostic vs. preventive services.

05/01/2013 - Updated reimbursement section to state that 91035 is not reimbursed and billing/coding guidelines to address claims for the use of approved anesthesia (00810) with preventive GI endoscopic procedures.

07/01/2014 - Added the screening ICD-10 codes that will be recognized as preventive.

05/01/2015 - Removed prior authorization requirement language for anesthesia associated with upper and/or lower GI endoscopic procedures.

01/01/2016 – Updated to new Plan template.

05/01/2016 - Updated billing/coding section to reflect removal of cost-share from pathology services associated with routine screening colonoscopies.

09/01/2016 - Added codes to the billing/coding section.

Connection date & details:

March 2017 – Removed deleted codes.

January 2018 – Removed moderate sedation exclusion, Code 91035 is now covered with approved prior authorization.

January 2019 – Removed termed code from billing section.

January 2020 – Clarified reimbursement section.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.