Oxbridge Health

Coding for Colonoscopies

Overview

The Affordable Care Act (ACA) mandates that insurers cover preventive services, such as screenings, with no cost-sharing for patients. This encourages early detection and preventative care.

A screening colonoscopy should have no patient due amount for an insured patient; a deductible and co-insurance are both waived. However, if the physician performs a diagnostic procedure (biopsy) or therapeutic procedure (polyp removal), it may no longer be considered a screening. Use of correct modifiers and sequencing the diagnosis code correctly would increase the likelihood that the service may still be regarded as screening by the payer.

Screening vs. Diagnostic Colonoscopies

Screening colonoscopy

Screening colonoscopies are performed on asymptomatic individuals based on age, gender, medical history, and family history, according to medical guidelines. The purpose is to look for evidence of colorectal cancer or polyps. Whether a polyp or cancer is ultimately found does not change the intent of the screening procedure.

Diagnostic colonoscopy

Diagnostic colonoscopies are performed in response to signs or symptoms to investigate and diagnose a condition, such as rectal bleeding and anemia.

Colonoscopy Guidelines

An Evaluation and Management (E/M) service prior to a screening colonoscopy is considered as part of the global payment for the screening. However, when the intent of the visit is a diagnostic colonoscopy, an E/M that takes place prior to the ordered procedure for a finding, sign, or symptom is a covered service and is subject to co-pay and deductible. But if a patient has a non-invasive screening test (FOBT or MT-sDNA test) and has a positive result, the subsequent colonoscopy will be processed as a screening test, not a diagnostic.

Members *not* at high risk for colorectal cancer are eligible for a screening colonoscopy once in 10 years. However, members at high risk of developing colorectal cancer are eligible for screening once in 24 months. These may also be called "surveillance" colonoscopies but they are billed and treated as screening colonoscopies. The high-risk criteria for colorectal cancer includes:

- A close relative (sibling, parent, or child) with colorectal cancer or an adenomatous polyp
- A family history of familial adenomatous polyposis
- A family history of hereditary nonpolyposis colorectal cancer
- A personal history of adenomatous polyps
- A personal history of colorectal cancer

- Inflammatory bowel disease

Procedure Code Guidelines

The CMS developed two HCPCS codes to help identify screening colonoscopies in the Medicare population. These HCPCS codes are:

  - G0105: colorectal cancer screening; colonoscopy for beneficiaries at high risk
  - G0121: colorectal cancer screening; colonoscopy for beneficiaries not meeting criteria for high risk

However, for our members, providers should use the following CPT code along with the appropriate screening diagnosis code.

- CPT code 45378: Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

Colonoscopy CPT Codes	
CPT Code	**Descriptor**
45378	Colonoscopy; flexible, diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	; with removal of foreign body/bodies
45380	; with biopsy, single or multiple
45381	; with directed submucosal injection(s), any substance
45382	; with control of bleeding, any method
45388#	; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45384	; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	; with transendoscopic balloon dilation
45389	; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed(
45390 #	; with endoscopic mucosal resection
45391	; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent

Colonoscopy CPT Codes	
	structures
45393	; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
45398 #	; with band ligation(s), e.g., hemorrhoids

= resequenced code

Common diagnosis codes for colorectal cancer screening

- Z12.11: encounter for screening for malignant neoplasm of colon
- Z80.0: family history of malignant neoplasm of digestive organs
- Z85.038: Personal history of other malignant neoplasm of large intestine
- Z85.048: Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
- Z80.0: Family history of malignant neoplasm of digestive organs
- Z86.010X: Personal history of colonic polyps
    - Z86.0100: Personal history of colon polyps, unspecified
    - Z86.0101: Personal history of adenomatous and serrated colon polyps
    - Z86.0102: Personal history of hyperplastic colon polyps
    - Z86.0109: Personal history of other colon polyps

Examples of other adjunct diagnosis codes that could be used in a secondary position are:

- K50.80: Crohn's disease of both small and large intestine without complications
- K63.5: Polyp of the colon

Screening Colonoscopy for Members that becomes Diagnostic or Therapeutic

If the procedure was initiated as a screening, the order (sequence) of the diagnosis codes is important. The appropriate screening diagnosis code should be placed in the first position on the claim form and the finding or condition diagnosis in the second position. In this example, first report Z12.11(encounter for screening for malignant neoplasm of colon) as the primary diagnosis followed by K63.5 (Polyp of the colon) as the secondary diagnosis. Additionally, the surgeon does not report the screening colonoscopy code 45378 but reports the appropriate code for the diagnostic or therapeutic procedure performed, from CPT code range 45379—45392.

If the procedure was initiated as a screening, the surgeon must document that the intent of the procedure was screening. This will allow the member's insurance to process the claim without any out-of-pocket expense in accordance with the ACA. The American Medical Association that has the copyright for CPT codes, developed modifier 33 for preventive services. For example, in the above example, if a surgeon performing a screening colonoscopy finds and removes a polyp with a snare, they can use CPT code 45385 and append modifier 33 to the CPT code.