

Insights to Coding and Data Quality

CPT© colonoscopy coding

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Providing the correct procedure codes to report colonoscopies continues to cause confusion for the professional coder. The American Medical Association (AMA) provides the Common Procedural Terminology (CPT) codes used to report outpatient procedures for hospitals and physicians. Medicare adds additional codes in the HCPCS (Healthcare Procedure Coding System). HCPCS includes both CPT, which is HCPCS Level I, *and* CMS-developed HCPCS Level II codes. The HCPCS codes are required for all Medicare outpatient hospital services, if they are available, unless specifically excepted in Medicare manual instructions. Let us take a look at some typical colonoscopy coding scenarios, and the CPT and HCPCS codes that should be reported.

Screening colonoscopy

AHA Coding Clinic provides guidance in assigning the principal or first-listed diagnosis code when the physician documents that the colonoscopy is performed for screening purposes only. Code V76.51 is used first and any findings such as polyps, diverticulosis, or hemorrhoids are listed second; see *Coding Clinic, First Quarter 1999 Page: 4*. CPT codes are reported based on the procedure documented, and whether the patient is Medicare. If the patient is not Medicare, the appropriate CPT, (HCPCS Level I) code is assigned. If the patient is Medicare and no other procedures, such as a polypectomy or biopsy are performed, then either code G0105 or G0121, (HCPCS Level II) codes are assigned. G0105 is assigned if the patient qualifies as high risk using the following criteria:

- A personal history of colorectal cancer or
- A family history of familial adenomatous polyposis or
- A family history of hereditary nonpolyposis colorectal cancer or
- A personal history of adenomatous polyps or
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis or
- A close relative (sibling, parent, or child) has had colorectal cancer or an adenomatous polyp.

HCPCS code G0121 is assigned if the patient does not qualify as high risk.

Screening colonoscopy with polypectomy

If the colonoscopy starts as a screening, but the physician finds polyps and performs a polypectomy, the principal or first-listed diagnosis code remains as V76.51. The polyp is reported as a secondary diagnosis code. The procedure reported will depend on the documentation and will include only the CPT, Level I HCPCS code(s). Medicare also requires the modifier PT to be added to the procedure code, when the screening colonoscopy becomes a

diagnostic colonoscopy. Use of this modifier will allow the Medicare patient to have the deductible waived.

Colonoscopy with different polypectomy techniques

When the colonoscopy includes more than one polypectomy technique, each technique may be reported separately if performed on different polyp sites. For example the physician performs a cold forceps polypectomy on a polyp in the descending colon, a polypectomy using snare in the rectum, and a polypectomy using hot forceps in the rectum.

Each procedure is reported using modifier 59 for the second two; see *Coding Clinic for HCPCS - Third Quarter 2006* Page: 4. If two techniques are used on the same polyp, such as a snare removal followed by hot cautery, only the hot cautery should be reported; see *CPT Assistant* January 2004, pages 5-7.

Colonoscopy with tattooing

Occasionally, the physician injects ink to identify a polypectomy or other suspicious sites in the colon when performing the colonoscopy. CPT code 45381, colonoscopy with submucosal injection, should be reported in addition to the polypectomy or other procedure; see *CPT Assistant*, June, 2010, page 4. A separate procedure modifier 59 is not required.

Colonoscopy with upper endoscopy

Quite often a colonoscopy is performed either just prior to, or just following an upper endoscopy, or esophagogastroduodenoscopy, (EGD). When this situation occurs, both the code for the colonoscopy and the EGD are reported. Modifier 59 is not required as the procedures are performed in different body systems. A high percentage of modifier 59 use could prompt a focus review by an outside agency.

It is important to understand the colonoscopy coding guidelines and associated procedures for both coding compliance and to obtain the correct reimbursement due to the facility. Performing routine audits to check the coding of this procedure will help to ensure proper coding.

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References

CPT Assistant, June, 2010, page 4

CPT Assistant, January 2004 Pages: 4,5-7

CPT Code Book, 2012

Coding Clinic, First Quarter 1999 Page: 4

Coding Clinic for HCPCS - Third Quarter 2006 Page: 4

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