



## ***Coding and Billing Colonoscopies, Flexible Sigmoidoscopies and EGD's***

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### **CPT® GUIDELINES:**

- Surgical endoscopy always includes diagnostic endoscopy:
  - 45330 Flexible Sigmoidoscopy, diagnostic**
  - 45378 Colonoscopy, diagnostic (proximal to the splenic flexure)**
  - 43235 EGD, diagnostic**
- If an incomplete colonoscopy is performed with full prep for a colonoscopy, use a colonoscopy code with the modifier -52 and provide documentation.
- If a biopsy is performed and the lesion is not excised, only code the biopsy.
- If a biopsy is performed and then the lesion is excised, only code the excision. The biopsy is included in the excision code.
- If multiple biopsies are taken from the same or different lesion, code the biopsy only once.
- If a biopsy is performed on one lesion and a different lesion is excised, both procedures are coded (see modifier -59).
- Two indented procedures in the same code family may be reported at the same time. The base procedure (e.g. 45330 for flex sig or 45378 for colonoscopy) would only be considered once by the payor.



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**CPT® CODES FOR COLONOSCOPY W/ BX OR LESION REMOVAL:**

- 45385 Ablation of Lesion(s) by Snare** – includes hot snare, monopolar snare, cold snare, or bipolar snare.
- 45384 Ablation of Lesion(s) by Hot Biopsy Forceps or Bipolar Cautery** – includes hot biopsy forceps or bipolar cautery.
- 45383 Ablation of Lesion(s) by Other Techniques** – includes techniques other than hot biopsy forceps (45384); bipolar cautery (45384); and snare (45385).
- 45380 Biopsy, Single or Multiple** – includes cold biopsy forceps or biopsy forceps.

**CPT® CODES FOR FLEXIBLE SIGMOIDOSCOPY W/ BX OR LESION REMOVAL:**

- 45338 Removal of Lesion(s) by Snare** – includes hot snare, monopolar snare, cold snare, or bipolar snare.
- 45333 Removal of Lesion(s) by Hot Biopsy Forceps or Bipolar Cautery** – includes hot biopsy forceps or bipolar cautery.
- 45339 Removal of Lesion(s) by Other Techniques** – includes techniques other than hot biopsy forceps (45333); bipolar cautery (45333); and snare (45338).
- 45331 Biopsy, Single or Multiple** – includes cold biopsy forceps or biopsy forceps.

**CPT® CODES FOR EGD W/ BX OR LESION REMOVAL:**

- 43251 Removal of Lesion(s) by Snare** – includes hot snare, monopolar snare, cold snare, or bipolar snare.
- 43250 Removal of Lesion(s) by Hot Biopsy Forceps or Bipolar Cautery** – includes hot biopsy forceps or bipolar cautery.



**43258 Removal of Lesion(s) by Other Techniques** – includes techniques other than hot biopsy forceps (43250); bipolar cautery (43250); and snare (43251).

**43239 Biopsy, Single or Multiple** – includes cold biopsy forceps or biopsy forceps.

## **MEDICARE BILLING INFORMATION FOR DIAGNOSTIC GI ENDOSCOPIES:**

- Special rules for multiple endoscopic procedures apply if one procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).
- Apply the multiple endoscopy rules to a code family before ranking the code family with the other procedures performed on the same day (for example, if multiple endoscopies in the same code family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).
- If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

- Base procedure is allowed once:

**45330 Flexible Sigmoidoscopy, diagnostic**

**45378 Colonoscopy, diagnostic (proximal to the splenic flexure)**

**43235 EGD, diagnostic**

- National Coverage Determination (NCD) for Endoscopy (100.2): “Endoscopic procedures are covered when reasonable and necessary for the individual patient.”
- National Correct Coding Initiative (NCCI): edits created by CMS “to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.”
  - There are two types of edits: Column1/Column 2 (comprehensive/component) and Mutually Exclusive.



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- In each edit pair there is modifier indicator that signifies whether a modifier can or cannot be appended in order to tell the payor to consider both procedures for reimbursement.
- Some non-Medicare payors use the CCI edits in their adjudication of claims; others use their own set of edits.

45378..... G0105°, G0121°  
45379..... G0105°, G0121°  
45380..... G0105°, G0121°  
45381..... G0105°, G0121°  
45382..... G0105°, G0121°  
45383..... 45384<sup>1</sup>, 45385<sup>1</sup>,  
G0105°, G0121°  
45384..... G0105°, G0121°  
45385..... 45384<sup>1</sup>, G0105°,  
G0121°  
45386..... G0105°, G0121°  
45387..... G0105°, G0121°

Modifier Indicator:  
0 = None Allowed  
1 = Allowed

## **MEDICARE BILLING INFORMATION FOR SCREENING GI ENDOSCOPIES:**

- Medicare considers **colonoscopies** and **flexible sigmoidoscopies** as colorectal cancer screening services:

### **G0104 Colorectal CA screening; flexible sigmoidoscopy**

- Screening flexible sigmoidoscopies may be paid once every 48 months (2 years) for pts 50 years of age and older, UNLESS:
- The pt does not meet the criteria for high risk of developing colorectal cancer, **AND** the beneficiary has had a screening colonoscopy (code G0121) within the past 10 years. If a pt has had a screening colonoscopy within the past 10 years, then the pt can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that the pt received the screening colonoscopy (code G0121).

### **G0105 Colorectal Cancer Screening; Colonoscopy on Individual at High Risk**



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- Screening colonoscopies may be paid once every 24 months (2 years) for pts 50 years and older at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed).
- Do not use code G0105 unless the pt meets high risk criteria for colorectal CA (see criteria below). Doing so could result in a denial as a non-covered service.

**G0121 Colorectal Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk**

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every 10 years but not within 47 months of a previous screening flexible sigmoidoscopy.

**HIGH RISK CRITERIA - “Beneficiaries are considered to be at high risk for developing colorectal cancer if they have:**

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
  - A family history of adenomatous polyposis;
  - A family history of hereditary nonpolyposis colorectal cancer;
  - A personal history of adenomatous polyps;
  - A personal history of colorectal cancer;
  - A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.”
- **Medicare considers a screening EGD a non-covered service:**

“Benefits for upper gastrointestinal endoscopy are not available for evaluations of patients with a positive family history of gastro-intestinal cancers without a personal history of symptoms. For some individuals with a strongly positive family history of



gastro-intestinal cancer, screening gastroscopy is appropriate, although Medicare does not cover it.”

- **Payment Methodologies**

- Flex Sig (G0104) and Colonoscopy screenings (G0105 and G0121) are paid under OPPS for outpt hospital departments.
- After January 1, 2007: the annual Medicare Part B deductible for these screening services is waived. However, coinsurance still applies. Coinsurance and deductible applies to the diagnostic colorectal service codes listed below. The following screening codes must be paid at rates consistent with the diagnostic codes indicated.

Screening Code	Diagnostic Code
G0104	45330
G0105 and G0121	45378

- As of January 1, 2008: A 25% coinsurance applies to both Flex Sig (G0104) and Colonoscopy screenings (G0105 and G0121) performed in ASCs and non-OPPS hospitals.

**MEDICARE BILLING INFORMATION FROM SCREENING TO DIAGNOSTIC GI ENDOSCOPIES**

- If during the performance of a screening flexible sigmoidoscopy (G0104) or a screening colonoscopy (G0105, G0121), a lesion or growth is detected which results in a biopsy or removal of the growth, the procedure becomes classified as a diagnostic procedure; and



the appropriate CPT® code(s) classified as a flexible sigmoidoscopy or colonoscopy with biopsy or removal should be billed and paid.

- If a screening flex sig or colonoscopy becomes a diagnostic flex sig or colonoscopy, the deductible would not be waived in such situations.
- The above scenario can be restated as follows:

*A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms. During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed. Although begun as a screening, the GI procedure is classified as a diagnostic because of the definitive findings. The appropriate CPT® code(s) should be submitted in this case rather than the screening HCPCS code in this case.*

## **MEDICARE BILLING INFORMATION FOR “INTERRUPTED” GI ENDOSCOPIES**

- “When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. However, the frequency standards associated with screening colonoscopies will not be applied.
- When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met, and the frequency standards will be applied. This policy is applied to both screening and diagnostic colonoscopies.”
- Facility providers are to suffix the colonoscopy codes with a modifier of “-73” or “-74” as appropriate to indicate that the procedure was interrupted.
- Professional providers are to suffix the colonoscopy code with a modifier of “-53” to indicate that the procedure was interrupted.



Endoscopic GI Procedure	CPT® Diagnostic (Base) Code	Medicare Payment Guidelines for Diagnostic	Part B Coinsurance & Deductible for Diagnostic	Medicare Screening Code	Medicare Guidelines for Screening	Part B Coinsurance & Deductible for Screening
Colonoscopy	<b>45378</b>	Special rules for multiple endoscopic procedures	Coinsurance & Deductible Applies	<b>G0105 (High Risk)</b>	Once every 24 months for pts meeting high risk criteria	Coinsurance Waived; 25% Deductible for ASC & Non OPSS Hosp
Colonoscopy	<b>45378</b>	Special rules for multiple endoscopic procedures	Coinsurance & Deductible Applies	<b>G0121 (Not High Risk)</b>	Once every 10 years but not within 47 months of a previous screening flex sig	Coinsurance Waived; 25% Deductible for ASC & Non OPSS Hosp
Flex Sig	<b>45330</b>	Special rules for multiple endoscopic procedures	Coinsurance & Deductible Applies	<b>G0104</b>	Once every four years for pts 50 years of age and older	Coinsurance Waived; 25% Deductible for ASC & Non OPSS Hosp
EGD	<b>43235</b>	Special rules for multiple endoscopic procedures	Coinsurance & Deductible Applies	<b>N/A</b>	Screenings not covered	Screenings not covered

**USE OF MODIFIERS:**

**Modifier -52: Reduced services**

- Used by professional and facility providers.





- Used to report that a procedure is reduced at the physician's discretion.
- If an incomplete colonoscopy is performed with full prep for a colonoscopy, use a colonoscopy code with the modifier -52 appended.

### **Modifier -53: Discontinued procedure**

- Used by professional providers.
- Used to report that a procedure was started but discontinued due to extenuating circumstances or those that threaten the well being of the patient. This modifier is not used to report an elective cancellation of a procedure.
- If a colonoscopy is attempted but interrupted due to extenuating circumstances, use a colonoscopy code with the modifier -53 appended.

### **Modifier -59: Distinct Procedural Service** (aka “unbundling modifier”).

- Used by professional and facility providers.
- Used to report that a procedure was distinct or separate from other services performed on the same day. It identifies procedures and services that are not normally reported together but are appropriate under the circumstances. Examples include: different session or patient encounter; different procedure or surgery; different site or organ system; separate incision or excision; separate lesion; or separate injury.
- Any circumstances that are not ordinarily encountered or performed on the same day by the same physician are subject to modifier -59. Inappropriate use (intentional or unintentional) could be considered fraudulent or abusive. Do not use modifier -59 just to bypass the NCCI edits. Overuse, whether intentional or unintentional, could trigger a payor audit.
- If a colonoscopy with biopsy is performed on one lesion, and a different lesion is removed, report both colonoscopy codes with modifier -59 appended to the biopsy code.



**Modifier -73: Discontinued OP Hospital/ASC Procedure Prior to the Administration of Anesthesia**

- Used by facility providers.
- Used to report that a procedure was cancelled due to extenuating circumstances or those that threatened the well being of the patient prior to administration of anesthesia (local, regional block or general). This modifier is not used to report an elective cancellation of a procedure.
- If a colonoscopy is cancelled due to extenuating circumstances before the pt was given anesthesia, use a colonoscopy code with the modifier -73 appended.

**Modifier -74: Discontinued OP Hospital/ASC Procedure After the Administration of Anesthesia**

- Used by facility providers.
- Used to report that a procedure was stopped due to extenuating circumstances or those that threatened the well being of the patient after the administration of anesthesia (local, regional block or general); or after the procedure started. This modifier is not used to report an elective cancellation of a procedure.
- If a colonoscopy is started but interrupted due to extenuating circumstances, use a colonoscopy code with the modifier -74 appended.



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Modifier	Code Description	Definition	Reporting Provider	Use
52	Reduced Services	Procedure is reduced at the physician's discretion.	Professional & Facility	<u>Incomplete</u> colonoscopy is performed with full prep for a colonoscopy, use a colonoscopy code with the modifier -52.
53	Discontinued Services	Procedure was started but discontinued due to extenuating circumstances or those that threaten the well being of the patient. Not used to report an elective cancellation of a procedure.	Professional only	Colonoscopy is attempted but <u>interrupted</u> due to extenuating circumstances, use a colonoscopy code with the modifier -53 appended.
59	Distinct Procedural Service	Used to report that a procedure was distinct or separate from other services performed on the same day. It identifies procedures and services that are not normally reported together but are appropriate under the circumstances.	Professional & Facility	Colonoscopy with biopsy is performed on one lesion, and a different lesion is removed, report both colonoscopy codes with modifier -59 appended to the biopsy code.
73	Discontinued OP Hospital/ASC Procedure Prior to the Administration of Anesthesia	Procedure was cancelled due to extenuating circumstances or those that threatened the well being of the patient prior to administration of anesthesia (local, regional block or general). This modifier is not used to report an elective cancellation of a procedure.	Facility only	Colonoscopy is cancelled due to extenuating circumstances before the pt was given anesthesia, use a colonoscopy code with the modifier -73 appended.



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74	Discontinued OP Hospital/ASC Procedure After the Administration of Anesthesia	Procedure was stopped due to extenuating circumstances or those that threatened the well being of the patient after the administration of anesthesia (local, regional block or general); or after the procedure started. This modifier is not used to report an elective cancellation of a procedure.	Facility only	Colonoscopy is started but interrupted due to extenuating circumstances, use a colonoscopy code with the modifier -74 appended.
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