Billing Guidelines for Screening Colonoscopy

Screening Colonoscopy vs Diagnostic Colonoscopy

A screening test is a test provided to a patient in the absence of signs or symptoms. A screening colonoscopy is a service performed on an asymptomatic person for the purpose of testing for the presence of colorectal cancer or colorectal polyps. Whether a polyp or cancer is ultimately found does not change the screening intent of that procedure. A diagnostic colonoscopy is a test performed as a result of an abnormal finding, sign, or symptom (such as abdominal pain, bleeding, diarrhea, etc.). Medicare and most payors do not waive the co-pay and deductible when the intent of the visit is to perform a diagnostic colonoscopy.

Billing Guidelines for Screening Colonoscopies

- For commercial and Medicaid patients, use 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]).
- For Medicare beneficiaries, use Healthcare Common Procedural Coding System (HCPCS) code G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) or

G0121 (Colorectal cancer screening; colonoscopy on individual not meeting the criteria for high risk) as appropriate. CMS developed the HCPCS codes to differentiate between screening and diagnostic colonoscopies in the Medicare population.

- To report screening colonoscopy on a patient not considered high risk for colorectal cancer, use HCPCS code G0121 and diagnosis code V76.51 (Special screening for malignant neoplasm of the colon). To report screening on a Medicare beneficiary at high risk for colorectal cancer, use HCPCS G0105 and the appropriate diagnosis code that necessitates the more frequent screening.
- It is not uncommon to remove one or more polyps at the time of a screening colonoscopy. Because the procedure was initiated as screening, the screening diagnosis is primary and the polyp(s) is secondary. The endoscopist reports the appropriate code for the diagnostic or therapeutic procedure performed, e.g., CPT code 45379—45392.
- CMS developed the PT modifier to indicate that a colonoscopy that was scheduled as the screening was converted to a diagnostic or therapeutic procedure. The PT modifier (Colorectal cancer screening test, converted to diagnostic test or other procedure) is appended to the CPT code. CPT developed modifier 33 for preventive services. If a physician performing a screening colonoscopy finds and removes a polyp with a snare, use CPT code 45385 and append modifier 33 to the CPT code.

Billing Examples

Example 1

- Indication: Colon screening
- Post-endoscopy finding: Normal colonic mucosa
- Procedure code: G0121 (Average risk screening) or 45378-33 (Diagnostic colonoscopy with modifier 33 indicating this is a preventive service).

- Diagnosis code: V76.51 (Special screening for malignant neoplasms, colon)

Example 2

- Indication: Personal history of colon polyps, Colon screening
- Post-endoscopy findings: Normal colonoscopy
- Procedure code: G0105 (High-risk screening) or 45378-33 (Diagnostic colonoscopy with modifier 33 indicating this is a preventive service)
- Diagnosis code: V12.72 (Personal history of colon polyps)

Example 3

- Indication: Colon screening
- Post-endoscopy findings: Polyps in the cecum and sigmoid colon
- Procedure: Colonoscopy with removal of cecal and sigmoid polyps by snare technique
- Procedure code: 45385 (Colonoscopy with removal of polyp by snare)
- Modifier PT (if Medicare patient) or Modifier 33 (if non-Medicare) should be added to indicate this was a preventive service and to trigger benefits
- Diagnosis code: V76.51 (Special screening for malignant neoplasms, colon). Some Medicare payors instruct to only use the finding since the PT modifier indicates it was done for screening.
- 211.3 (Benign neoplasm, colon [based on pathology report])

Example 4

- Indication: Personal history of colon polyps; Colon screening
- Post-endoscopy findings: Large sessile polyp in the rectum, unable to resect, pending pathology

- Procedure: Colonoscopy with biopsy of the rectal polyp. Will await pathology and consider surgical referral.
- Procedure code: 45380 (Colonoscopy with biopsy)
- Modifier PT (if Medicare) or Modifier 33 (non-Medicare) should be added to indicate this was a preventive service and to trigger preventive
- Diagnosis code: V12.72 (Personal history of colon polyps). Some Medicare payors [First Coast and Noridian] instruct to only use the finding since the PT modifier indicates it was done for screening.
- 211.4 (Benign neoplasm, rectum) or 235.2 (Neoplasm uncertain behavior, intestines and rectum [based on pathology report]).

Example 5

- Indication: Change in bowel habits, here for colon screening
- Post-endoscopy findings: Normal colon
- Procedure: Colonoscopy
- Procedure code: 45378
- Do not append modifier 33 or PT, as this service was performed for a diagnostic, not screening, indication.

Understanding the business side of medicine helps physicians run a successful practice. However, the business side of medicine is not part of the normal curriculum in training and fellowship programs. Physicians come out of training with the knowledge to treat patients but with little or no knowledge of how to get reimbursed for their services.

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