



Coding and reimbursement for colonoscopy

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This month's column addresses coding and reimbursement questions regarding a procedure performed by many general surgeons: colonoscopy.

Coding issues

Much of the confusion with respect to coding for colonoscopy arises from the dichotomy between screening and diagnostic colonoscopy. Screening colonoscopy is defined as a procedure performed on an individual without symptoms to test for the presence of colorectal cancer or polyps. Discovery of a polyp or cancer during a screening exam does not change the screening intent. Surveillance colonoscopy is a subset of screening, performed at an interval less than the standard 10 years from the last colonoscopy

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(or sooner, in certain high-risk patients), due to findings of cancer or polyps on the previous exam. The patient in this case is also asymptomatic. Unlike the two procedures mentioned previously, a diagnostic colonoscopy allows physicians to evaluate symptoms, such as anemia, rectal bleeding, abdominal pain, or diarrhea.

Understanding the difference between screening and diagnostic colonoscopies has become increasingly important in recent years, especially after the enactment of the Affordable Care Act, which mandates that insurers pay the full cost of screening examinations without collecting a deductible or copayments from patients. Consequently, endoscopists saw an increase in the volume of screening examinations beginning in 2011. Unfortunately, many of them also experienced an increase in calls from patients regarding their bills.

A screening colonoscopy should be reported with the following International

Classification of Diseases, 10th edition (ICD-10) codes:

- Z12.11: Encounter for screening for malignant neoplasm of the colon
- Z80.0: Family history of malignant neoplasm of digestive organs
- Z86.010: Personal history of colonic polyps

If a polyp is found and removed during the same procedure, these codes should still be listed as the primary diagnosis codes, followed by the appropriate ICD-10 code for polyp: D12.0–D12.9 (benign neoplasm of the colon or rectum, based on location).

All Current Procedural Terminology (CPT) codes for colonoscopy were revised for 2015.* Several new CPT codes were introduced for interventional colonoscopy procedures, which were not valued for 2015; however, all of these codes have been valued

for 2016 and are reimbursed by Medicare and private insurance plans. Several clarifications were made in the 2015 revision, including the following:

- Colonoscopy is no longer defined as endoscopy beyond the splenic flexure; to be considered a colonoscopy, the examination must be to the cecum (or to the enterocolic anastomosis if the cecum has been surgically removed).
- All colonoscopy procedures now include the provision of moderate sedation.
- Incomplete colonoscopies not reaching the splenic flexure are reported as flexible sigmoidoscopies.
- Incomplete screening or diagnostic colonoscopies that reach beyond the splenic flexure but not to the cecum are reported with modifier 53. This allows future payment for a repeat examination before the usual screening interval.
- Therapeutic colonoscopies that are incomplete (the scope does not reach the cecum during a therapeutic procedure) are reported with modifier 52.

It is important to note that the codes for reporting these procedures differ between Medicare and other payors. For

non-Medicare payors, use the CPT conventions. Colonoscopy codes are listed in the digestive section of CPT, codes 45378–45398 (or codes 44388–44408, if performed through a stoma rather than the anus). CPT code 45378 is the base code for a colonoscopy without biopsy or other interventions. It includes brushings or washings, if performed.

If the procedure is a screening exam, modifier 33 (preventative service) is appended. This indicates to payors that the procedure should be reimbursed without regard to patient copayment or deductible. This modifier also may be appended to therapeutic colonoscopies, such as 45385 (colonoscopy, with removal of tumor, polyp, or other lesion by snare technique). By using this modifier and the proper diagnosis codes, the endoscopist tells the payor that the diagnostic procedure is done for screening.

The base value of the code is not subject to a copayment, but the patient may be required to remit a copayment for the additional cost of the therapeutic procedure.

Medicare uses Healthcare Common Procedure Coding System (HCPCS) codes for screening. For a patient of typical risk, the screening procedure is reported with HCPCS code G0121; for a patient at high risk, it is reported with HCPCS code G0105. Medicare has a separate modifier for situations in which

polyps are found and removed during a screening colonoscopy. In these instances, the correct CPT code is used (for example, 45385), but with modifier PT. Medicare's reimbursement policy for this type of case is the same as other payors; only the coding differs. Each endoscopist should review the policies of their insurance providers to be certain which system is used, especially for Medicare Advantage plans offered by commercial insurers.

In 2015, Medicare also stated that for patients undergoing screening colonoscopy with sedation provided by anesthesia professional, the copayment and deductible would not apply to the separate charge for anesthesia.

Reimbursement issues

All endoscopy procedures have a base value for the diagnostic procedure and incremental additional work relative value units (wRVUs) for additional diagnostic or therapeutic procedures, such as biopsy, snare polypectomy, stent placement, and so on. These increments are consistent among the different endoscopy families (esophagogastroduodenoscopy, sigmoidoscopy, and colonoscopy). When multiple procedures such as snare polypectomy of one lesion and biopsy polypectomy of another, are performed at the same setting, the total wRVU would be the base wRVU and

RESOURCES FOR COLONOSCOPY CODING AND REIMBURSEMENT

- **American Gastroenterological Association website**
www.gastro.org/practice-management/coding/screening-colonoscopy-faq
- **CMS preventative services chart**
www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf
- **CMS fiscal year (FY) 2015 final rule**
www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html
- **American Academy of Professional Coders: ICD-10 crosswalk**
www.aapc.com/icd-10/crosswalks/
- **Karen Zupko & Associates**
www.karenzupko.com/preventive-screening-services/
- **Betsy Nicoletti Notes: Coding for screening colonoscopies**
<http://nicolettinotes.com/2013/09/26/coding-for-screening-colonoscopy-5/>

the sum of the incremental additional values. For example, the base wRVU for a diagnostic colonoscopy (CPT code 45378) is 3.36. The incremental wRVU of cold biopsy is 1.02, so the total wRVU of colonoscopy with cold biopsy by forceps is 4.38.

Reimbursement for all colonoscopy procedures decreased substantially in 2016. This decline was not news to those individuals involved in the American Medical Association (AMA) or government valuation process; it had been coming since 2011. The reasons for this reduction, and the behind-the-scenes work on this one issue, illustrate a great deal about the process of coding and valuation of physician services. For several years, it had been widely recognized that colonoscopy was increasingly being performed with the presence of an anesthesia provider. Most flexible endoscopy procedures had originally been described and valued with the inclusion of conscious sedation, a term that has become obsolete and has been replaced with such phrases as light sedation, moderate sedation, and deep sedation, or general anesthesia.

The introduction of propofol as a sedating agent changed the approach to procedural sedation. Studies reported that actual procedure times were significantly less than the times upon which the relative values

for endoscopy had been based. Partly because of these data, the Centers for Medicare & Medicaid Services (CMS) directed the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to review all endoscopy codes. The RUC referred the entire code set back to CPT to reconsider the codes. For the period of three years, all of the codes beginning with upper endoscopy and enteroscopy were reconsidered, and a new code set was created. Colonoscopy codes were completed lastly, in time for valuation for the 2015 final rule from CMS.

The valuation process for endoscopy, and especially for colonoscopy, was debated at the RUC meeting. The gastrointestinal (GI) specialty societies that valued the new codes using the RUC survey process proposed a modest reduction in value. The RUC as a whole, however, disagreed and assigned value reductions between 4 percent and 23 percent. Before the 2015 final rule, the GI societies, along with the American College of Surgeons, the Society of American Gastrointestinal and Endoscopic Surgeons, and the American Society of Colon and Rectal Surgeons, appealed the ruling directly to CMS, resulting in an additional one year delay in revaluation. However, CMS ultimately agreed with the RUC valuation

and enacted the new values for 2016. As a result, the wRVUs for diagnostic colonoscopy, CPT code 45378, decreased 9 percent, from 3.69 to 3.36.

The colonoscopy code set still includes moderate sedation. Therefore, the endoscopist may not report an additional code for supervision of moderate sedation (99143–99150) or anesthesia (00740 or 00810). A second physician, other than the one performing the procedure, may report the codes for moderate sedation or anesthesia if he or she provides this service.

At this time, the endoscopist is not required to report a reduced service (modifier 52) in this situation. However, this policy may change in the future, or further devaluation of the base endoscopy procedures may occur if the work of sedation is removed from the current valuation.

Sample case

A 50-year old patient without family or personal history comes for a screening colonoscopy, in which three polyps are found: a 10 mm polyp is removed from the cecum by snare technique after injection of saline to “lift” the polyp, a 5 mm polyp is removed from the descending colon by cold biopsy forceps, and a 5 mm polyp is removed

from the rectum by cold biopsy forceps. The procedure is done with a certified registered nurse anesthetist (CRNA) providing moderate sedation.

Diagnoses

- Z12.11: Encounter for screening for malignant neoplasm of the colon (note: it is important that the Z code is listed first)
- D12.0: Benign neoplasm of the cecum
- D12.4: Benign neoplasm of the descending colon
- D12.8: Benign neoplasm of the rectum

Procedures

- 45385–33: Colonoscopy with snare polypectomy; modifier to indicate preventative screening procedure.
- 45380–59: Colonoscopy with biopsy, single or multiple; modifier to indicate distinct procedures. Note: report only once, even if multiple polyps are removed by the same technique.
- 45381–51: Colonoscopy with submucosal injection (any substance); modifier to indicate multiple procedures at the same setting.
- The CRNA reports 99149–33: Moderate sedation services, provided by a physician other

than the physician performing the diagnostic service; modifier to indicate preventative screening procedure.

Reimbursement

- The endoscopist will be reimbursed 4.67 wRVU for colonoscopy with snare + 0.3 wRVU for the submucosal injection + 1.02 wRVU for the biopsy polypectomies, for a total of 5.99 wRVU. The total reimbursement also includes practice expense RVU and liability RVU; the sum is multiplied by a conversion factor determined by the payor.
- The CRNA will be reimbursed at a rate determined by the payor, as the moderate sedation has not been assigned a relative value.
- The patient would be exempt from a copay for the value of the screening colonoscopy (3.36 wRVU) and the sedation. The patient would be responsible for a copay on the additional 2.63 wRVU from the therapeutic procedures. ♦