Codify
BY AAPC

Internal Medicine Coding Alert

Polypectomy; 45380-45385: Learn 3 Tips For Proper Polypectomy Coding

If the surgeon spends double time on 45385, bill with modifier 22.

If you know how to work out the type of scope, surgical technique, and polyp location from your GI's colonoscopywith-polypectomy claim, you're half way into coding success. But you also have to recognize the different types of polyp removal, and the removal method used or you could watch your effort just go down the drain.

Here are three tips on what you should not do.

1. Don't Overlook Your Physician's Colonoscopy, Polypectomy Technique

The key is to understand your GI's operative report. If you look closely, you should be able to verify if she actually performed a colonoscopy, and what method she used to remove the polyp (either with biopsy or snare technique). CPT® carries different codes for polypectomies, and it's important that you know which technique your physician used to bill the service correctly, warns **Dena Rumisek,** biller for Grand River Gastroenterology PC in Grand Rapids, Mich.

In case of multiple polyp removal, you should know where on the colon each polyp was located. Particularly, you should be able to tell whether they were in separate locations or close enough for payers to consider one location. The number of allowable codes would depend on the number of polyp locations.

2. Don't Forget The Difference Between 'Cold' and 'Snare'

When, during a colonoscopy, the GI takes tissue samples or removes a small polyp using cold biopsy (disposable) forceps, it means she's performed **CPT 45380** (Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple). These forceps are referred to as "cold" because no electric current passes through them. Procedure 45380 usually translates to a partial polypectomy.

On the other hand, when the gastroenterologist uses snare technique during a total polypectomy, you should report 45385 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique).

Example: During a colonoscopy, the physician encounters an unusually high number of polyps -- 14 polyps. She, then, removes the polyps using a snare. In this case, you should report 45385 with modifier 22 (Increased procedural services) to compensate for the double amount of the physician's time. Take note, the usual standard when reporting 45385 with modifier 22 is double the amount of time that the procedure normally takes.

Important: When reporting such a claim, you should bulletproof your documentation including a full note that describes the procedure in detail, as well as the time the physician had to devote to the procedure and how this differs from a "typical" procedure of the same type. Also, include a cover letter explaining the unusual nature of the procedure in brief (for instance, "The physician had to remove 14 polyps. Typically he must remove only 1-3.") and asking for increased reimbursement.

Another take on our example: suppose the physician removes a polyp using the snare technique, but during the same session (while investigating the transverse colon), he sees a suspicious area that he injects with India ink. You would report 45385-22 for the polypectomy, and 45381 (... with directed submucosal injection[s], any substance) for the injection.

3. Don't Exclude Cauterization, Ablation Options

Sometimes, the physician would have to control a patient's bleeding, and perform cauterization. Regardless of the method the physician uses (for instance, Argon laser), you should reportthe control-of-bleeding code 45382 (Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator]).

Surgeons may use many of the same techniques for cauterization (to control bleeding) and for ablation. But the defining factor is the diagnosis. For example, use 45382 when controlling bleeding from a polyp removed several days ago or for diverticulosis (562.12, Diverticulosis of colon with hemorrhage; or 562.13, Diverticulitis of colon with hemorrhage). Another application is for angiodysplasia 569.85 (Angiodysplasia of intestine with hemorrhage).

You would use the ablation code 45383 (Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) if the physician were ablating or fulgurating a nonbleeding polyp, tumor or lesion by a means other than hot biopsy. You shouldn't apply 45383 when the physician uses:

- hot biopsy forceps (report 45380 instead)
- bipolar cautery (bill 45384 on your claim), or
- snare technique followed by ablation (report 45385)

Tip: Gastroenterologists often use the ablation code for follow up colonoscopy. If the polyp removed during the initial colonoscopy was benign, the physician may perform a followup colonoscopy a few months later. Sometimes, when the physician uses snare to remove the initial polyp, there are some cells still present that must be removed at a later date.

Treating the site with argon plasma coagulators (APC), which uses argon gas to deliver thermal energy to a field of tissue adjacent to the probe, is one of the more popular methods for destroying the leftover cells. Be careful, however. Not all follow-up visits to remove the remainder of the polyp will include ablation. If snare technique is used, you should report 45385.