

Part B Insider (Multispecialty) Coding Alert

Reader Question: Remember to Report Primary Reason for Procedure First

Question: Our GI just performed a colonoscopy on a Medicare patient for control of bleeding. The provider encountered and decided to remove a polyp. I am planning to report 45382 and 45385. Which codes should I bill first and with what modifier?

Answer: You should report code 45382 (Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding [eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator]) first. The reason is that this is the primary reason for the colonoscopy and the higher paying procedure out of the two. This decision assumes that a bleeding site separate from the polyp was identified and controlled with one of the methods listed. You should attach modifier 59 (Distinct procedural service) with 45385 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique) for the polyp removal by snare.

You have to make sure that the documentation includes the fact that control of bleeding is the primary reason for the colonoscopy. If the bleeding occurs due to the polyp removal and the GI decides to undertake control of bleeding subsequently during the same operative session, then the control of bleeding service is included in the primary procedure (45385) and you cannot report both of the codes separately.

Endoscopies have been grouped according to families, with each family represented with a base code. In cases of multiple procedures, CPT®'s multiple endoscopy rules apply. If you are reporting two codes and one of them is a base code, then you can only report the non-base code as that code includes the work reported by the base code. In a case like yours, both the codes being reported belong to the same family but none is a base code. The base code here will be 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]). Therefore, a different rule will apply wherein Medicare will pay for the most extensive (i.e., highest-valued) scope at 100 percent value. Then, Medicare will pay all additional scopes in the same family by subtracting the value of the base endoscopy and paying the difference.