Codify
BY AAPC

Outpatient Facility Coding Alert

CPT® Coding: Boost your Colonoscopy/Sigmoidoscopy Coding Skill Set with these Examples

Identify important differences between biopsy and removal via technique.

If colonoscopy and sigmoidoscopy coding puzzles you, you're certainly not alone. The process of breaking down a complex operative report and reaching the correct procedural code can challenge even the most seasoned coders.

Take a look at these two examples to help clear the air on two of the most commonly miscoded colonoscopy and sigmoidoscopy clinical scenarios.

Know When to Convert from Screening to Removal

Example 1: Medicare patient with a family history of familial adenomatous polyposis undergoes a colonoscopy screening procedure. During the procedure, the provider encounters multiple polyps. The provider removes the polyps by snare technique to be sent for biopsy.

Since you are coding for a Medicare patient, you will want to consider an appropriate HCPCS screening code, if applicable. If the screening exam yielded clean results, the coding would be simple. The only distinction you would need to make is determining whether or not the patient's encounter qualifies as a high-risk screening. According to Medicare, you may bill out using code G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) if the patient meets one of the following criteria:

- Close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp.
- Family history of familial adenomatous polyposis.
- Family history of hereditary nonpolyposis colorectal cancer.
- Personal history of adenomatous polyps.
- Personal history of colorectal cancer.
- Irritable Bowel Disease (IBD), including Crohn's disease, and ulcerative colitis.

A family history of familial adenomatous polyposis means this patient meets the criteria for a high-risk screening colonoscopy. However, since the documentation does not support a clean screening colonoscopy, you will have to switch gears and determine the correct CPT® code for the services rendered.

Make the Proper Distinction Between 45380, 45385

Once you know to utilize the CPT® manual for the correct colonoscopy code, your decision becomes simpler. However, some coders may have trouble deciding whether to code this as 45380 (Colonoscopy, flexible; with biopsy, single or multiple) or 45385 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique). Ultimately, your decision should come down to the method of removal, not the intent.

"Understand that there are two types of possible scenarios when it comes to colonoscopy with biopsy," says **Leslie Johnson, CPC**, coding and auditing consultant at Oasis Medical and Surgical Wellness Group, LLC, in Glen Rock, New Jersey. "Anything that is removed from the body is sent to the lab for biopsy. So, if the surgeon spots a polyp during the exam, it may be removed and the specimen will be sent to the lab for identification. Another scenario might be when the surgeon notes a suspicious lesion, he or she may not remove the entire thing, but rather take a sampling of it," Johnson explains.

For the first scenario, you will base your code on the surgeon's polyp removal technique. For example, if the surgeon

uses hot biopsy forceps, you will apply code 45384 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps). However, if the provider performs a sampling for biopsy as Johnson describes in the second scenario, you will opt for code 45380 (Colonoscopy, flexible; with biopsy, single or multiple). Using the original example above, the correct code for a colonoscopy with polypectomy using a snare technique is 45385.

Use 1 Code for Multiple Removals of Extended Lesion

Example 2: The patient presents for a sigmoidoscopy due to an extended lesion of the sigmoid colon. The provider removes one portion of the lesion using a hot snare technique and removes another portion of the lesion using hot biopsy forceps.

Sometimes, when performing a colonoscopy or sigmoidoscopy, the provider may encounter an extended lesion or two separate lesions within the same site. Just as surgeons would if they individually remove both separate lesions, the extended lesion may require removal at two separate sites.

It's important to keep in mind that the coding process differs depending on which of these two situations you encounter. In the example above, the lesion is "extended," or stretches further along the sigmoid colon than what is typical or expected. In this case, the provider will remove one portion using a hot snare technique and a second portion along the extended lesion using hot biopsy forceps. In terms of coding, you only should apply one code since the physician is technically only performing the service on one lesion.

At first, you might expect to opt for the code with the higher relative value units (RVUs), 45333 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps). However, when performing a Correct Coding Initiative (CCI) edit check, you will see that 45333 is actually a column 2 code for 45338 (Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique). So, in this example, you should exclusively bill for code 45338.

Not so fast: If the physician goes above and beyond the typical time estimation for code 45338, you may consider use of modifier 22 (Increased Procedural Services) when billing for the physician. In order to properly use modifier 22, CPT® advises that the documentation supports "the substantial additional work and the reason for the additional work (i.e. increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, etc.)." In the example of the extended lesion sigmoidoscopy, the physician and coder may want to consider the time factor, above all else, as a reason for application of modifier 22.

However, note that modifier 22 does not apply in the hospital outpatient setting. When billing for the facility, there is no modifier available equivalent to that of modifier 22.

Consider Modifiers 59, XU

If the surgical example involves multiple, separate lesions, you may bill out using two codes since the provider removes lesions from two separate sites. Despite the fact that the provider documents the lesions at the same anatomic site (sigmoid colon), a modifier 59 (Distinct Procedural Service) or XU (Unusual Non-Overlapping Service) is allowed to distinguish the two operations. However, make sure there is appropriate documentation explaining that the two lesions are anatomically separate from one another.

Consider: Some coders may consider modifier XS (Separate Structure) over XU; however, this example does not describe surgery on a separate "organ or structure." Rather, you should designate XU to explain to the payer that, while the second procedure is performed on the same general anatomic area, the diagnostic reasoning behind the two services are entirely distinct from one another.