Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Code Your Colonoscopy With 45383 and 45381

Question: The doctor used an Olympus scope guide in the transverse colon. The report suggests that the lesion was at approximately 9 cm in the rectosigmoid or upper one third of the rectum. A rotable snare was used, the base was encircled and the polyp removed. Then another small piece that was still on the wall was removed, thereby, removing the entire lesion. The lesion was retrieved and put in a pathology bottle. The portion was again examined. There was a diagnosis of dysplasia, and Argon plasma coagulation (APC) was performed. Using APC with 360 head post-polypectomy setting, the entire area was APC'd under narrow band light. This was removed, the Argon removed, and then a tattoo with a SPOT material was used and photographs were taken.

What codes should I use to report this procedure?

Florida Subscriber

Answer: It is apparent from the report that the snare and APC intervention are on the same polyp/lesion.

The scope was passed only to the transverse colon, so if the procedure was planned as a sigmoidoscopy then you would use CPT(R) codes from the flexible sigmoidoscopy family of codes even if the scope went beyond the splenic flexure. If the procedure was planned as a colonoscopy then you should use the following codes on your claim:

- 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
- 45381 – Colonoscopy, flexible, proximal to splenic flexture, with directed submucosal injection[s], any substance.

Billing tip: You should not report 45385 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique). CCI edits bundle this code into 45383.

The Relative Value Units (RVUs) for 45385 (14.82 total RVUs for non-facility) are lower than that for 45383 (15.96 total RVUs for non-facility). So it would be a good idea to use the latter code when appropriate. If your documentation supports 45383, it will bring you a higher reimbursement: $571.73 versus $530.89 for 45385 (using the 2014 national Medicare conversion factor of 35.8228). In this case, however, you cannot unbundle the edit by using modifier 59 because both interventions are on the same polyp. You would bill the tattooing with 45381.

Remember: Each CPT® code has a Relative Value Unit (RVU) assigned to it which, when multiplied by the conversion factor (CF) and a geographical adjustment (GPCI), creates the compensation level for a particular service.