Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Reporting Anesthesia for Colonoscopy

Question: I bill the anesthesia for a GI physician, and lately he's been asking us to change the diagnosis code to "screening" when the procedure and diagnosis codes are 45384 and 211.3. Is it appropriate to change the diagnosis to V76.51 and still report 45384? Should we include modifier PT to show it went from a screening to a diagnostic procedure?

North Dakota Subscriber

Answer: Sometimes a patient is scheduled for a screening, but then the physician finds polyps (or other complications) during the procedure. If so, the GI physician can report the procedure with 45384 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery) and primary diagnosis V76.51 (Screening colonoscopy NOS), and secondary diagnosis 211.3 (Benign neoplasm of colon) since a polyp was found and removed.

Modifiers: When coding for the physician service, you'll want to include modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure). When coding for the anesthesia, however, you won't need the modifier. You'll simply report 00810 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum) with the appropriate number of time units based on how long the procedure lasted.

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