Outpatient Facility Coding Alert

Reader Question: Take a Note of the Gap Between High-Risk and Average-Risk Screenings

Question: We recently had a Medicare patient come to the office for a screening colonoscopy. He underwent an incomplete colonoscopy in December 2014 (only to the hepatic flexure) and now has bleeding hemorrhoids. From the op note, there were no abnormalities noted then. They just could not get past the hepatic flexure, after trying for 35 minutes and therefore, decided to terminate the procedure. He has no known diagnosis of colon cancer or polyps; however, he does have a history of prostate and laryngeal cancer and is concerned about having colon cancer. Doctor wants to perform a colonoscopy. Can this colonoscopy be billed? Also, what is the correct coding for an aborted colonoscopy for poor bowel prep?

Alabama Subscriber

Answer: According to Medicare's time restriction, there should be a two-year gap between two high-risk screenings and a ten-year gap between two average-risk procedures. If a screening is repeated in one year, it will be denied by Medicare as "not medically necessary." If the physician wants to repeat within the restricted time, the first procedure should have been billed with modifier 53 (Discontinued procedure), even though the scope advanced beyond the splenic flexure.

However, because of the now bleeding hemorrhoids, you could use rectal bleeding as a diagnosis and be able to bill out the colonoscopy now as diagnostic. In such a case, you could report codes:

- 45378 (Colonoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure])
- K62.5 (Hemorrhage of rectum and anus).

For an aborted colonoscopy for poor bowel prep, report the intended procedure with modifier 53 for the professional service, e.g., 45378-53, or with modifiers 73 [Discontinued Outpatient/Hospital Ambulatory Surgery Center (ASC) Procedure prior to the administration of anesthesia] or 74 [Discontinued Outpatient/Hospital Ambulatory Surgery Center (ASC) Procedure after the administration of anesthesia] for the technical component, depending upon the use of anesthesia. You can also use Z53.8 (Procedure and treatment not carried out for other reasons) as a secondary diagnosis.