Outpatient Facility Coding Alert

You Be the Coder: Be Careful With Coding Incomplete Colonoscopies

Question: Our provider started the procedure with an intention of performing total colonoscopy. However, during the procedure, he could not advance the colonoscope to the cecum and had to discontinue the procedure. How do we code for this scenario?

Mississippi Subscriber

Answer: The appropriate code choice for this scenario will be based on the type of procedure being performed, whether it was therapeutic or diagnostic. In the past you could report a full procedure code if the colonoscope passed the splenic flexure; however, 2016 onwards, the definition of a complete colonoscopy must include reaching the cecum unless it is absent or unreachable due to an identified obstructing lesion. Inability to reach the cecum due to technical difficulty means the procedure is incomplete.

In cases when the provider was performing a diagnostic or screening endoscopic procedure and was unable to advance the colonoscope to the cecum, you may report CPT® 45378 (Colonoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) with modifier 53 (Discontinued procedure) for the professional component and modifier 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 administration of Anesthesia) for the facility one. In addition, you must remember to provide appropriate documentation of the service provided.

If the provider performed therapeutic colonoscopy and same situation occurred, you may report the appropriate therapeutic flexible colonoscopy code such as 45380-45398, with modifier 52 (Reduced services), along with the needful documentation describing the situation and why the procedure could not be completed.